			For State Registrar	State of	Marylan	-	artment of F rtificate of I				iene eg. No 2 0 0 9	9 04001
	nysicia Medic	al .		re						Date of Deat Month Z	Day Year	810 A M
Fui	neral	-1	4a. Facility Name (If not institution  Unjuess; by of  5. Social Security Number	Maryland	. Age (In yrs.	Vre	4b. City, Town, or 3allimos If Under 1 Year Months Days		24 Hrs. 8. [ Min.	Date of Birth	Year)	Birthplace (State or Foreign Country)
70	ector	tor	251-48-6154  Usual Residence of Decedent  10a. State  10b. County			8 I ty, Town or Lo			MA	AY 12	1927   SO	UTH CAROLINA  10d. Inside City Limits  XXYes 2 □ No
th with the	ant be notif	ral Director	MARYLAND   N/A 10e. Street and Number 309 W. MOSHER	STREET	1-7	BALTI	10f. Zip Code	L217		1	0g. Citizen of What	Country?
0036 ours after dea	Examinar m	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3XXWidowed 4 ☐ Divorced	ied 12. Was Decede Armed Force 1 TYes 2. If Yes, Give Year or Date	8\$? <b>X</b> }X⊍o		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 <b>%</b> No	lispanic Or an, Mexican Specify:		Yes or No- in, etc.)	14. Race - Ai Black, Wi Specify: B	•
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene, Hygiene, 222, or 282, ethorus	, the Medical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 12th grade	t's Education st grade completed) College (1-4	or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired TRESS	during mos i)			16b. Kind of Busines	-
aryland should be file and Mental Hy	natic event	To Be	17. Father's Name (First, Middle, GARY MOORE			1.01 44 #		M	ARY GEN	WRIGH		
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours aft partment of Health and Mental Hygiene.	imporant, it ten 27 is marked once than italical examinational by notified at once. Once.		19a. Informant's Name/Relations  Valerie H. Sam  20a. Method of Disposition  XXBurial 2 □ Cremation	pson/Niece	20b. F	311 W		St.,		more,	r, City or Town, State Maryland 20c. Location - City	21217 or Town, State
Baltimo	any Injury once.		4 Donardon 5 Dother (S. 21. Signar re of Funeral Service	-	OL	22 W	CEMETERS Name and Addres LLLIAM C 206 W NOR	ss of Facili BROW	02-14-0 N COMMU VENUE,	JNITY	GRESHAM, FUNERAL H MORE, MD	SOUTH CAROLING OME P.A. 21217
8760, Sate be executed Exam Shysician and	dical iner	dical Examiner	28ar Part 1. Enter the disease, or shock, or heart fallure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Coro Due to (or  c. Dial	h line.	Arte: quence of):	distage	g, 50011 ac		ginatory an		Approximate Interval Between Onset and Death
Box 6 eath certifi	for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown		th 2□Feta nt at time of o	I death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у			23d. Date of Month	delivery Day Year
ords, Pequires that	ped	þ	Part II. Other significant condition	ons contributing to dear	th but not res	ulting in the u	nderlying cause give	en in Part I				e to the cause of death?
Ital Reco an: The law r Tificate has be	age 2	Be Completed	25. Was case referred to medical					26 Place	e of Death (Cf		sy prior med? death 2 No 1 □ Y	autopsy findings available to completion of cause of 1? Yes 2 No
DIVISION Of VITAI RECORDS, To the Hospital or Attending Physician: The law requires th within 24 hours after death. To the Funeral Director: After this certificate has been sinner	y the funeral direc	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin 2 Accident investit 3 Suicide 6 Could	28a. Date of (Month, gation not be	Injury <i>Day, Year)</i>	ER/Outpatier 28b. Time of Injury	28c. Injur Work	er: 4 🗆 N	ursing Home 28d.	5 ☐ Reside	ence 6 ☐ Other (Sow injury occurred	Specify)  Rural Route Number,
DIV e Hospital or / 124 hours after e Funeral Dire	eletely filled in b	edical Certif	4 Homicide determ  29a. Certifier (Check only one)  1 Certifyir 2 Medical	ng Physician: To the b Examiner: On the bas and manne	est of my kno	fy)  owledge, deat	h occurred at the tir	me, date a	nd place, and	due to the o	n, State)  cause(s) and manne	r as stated.
To the within	ф	Me	29b. Signature and title of certifier				29c. Licens	e number	1	2	29d. Date signed (Mo	onth, Day, Year)
3	Stol		30. Name and address of person  Hanh Trum  31. Date filed (Month, Day, Year)	22 5	. Gre	eNe.	Baltin	nore,	MD 2	1201		
R	Stat egistra		FFR 1 1 2009	Benus	A.	park						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>009</u> Physician 6:12A Feb. /Medical Hampton A. Riggs 4a. Facility Name (If not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Towson Gilchrist Center 8. Date of Birth (Month, Day, Tilly 7 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** . 1932 Maryland Months Days Hours 1 M 2□F 215-28-8614 Director 76 Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location Baltimore 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examination at N/A Maryland 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21213 1633 Milton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 52 Yes 2 □ No 1951 -If Yes, Give Year or Dates: 1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married "natural", or if Specify: Black 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hotels Maintenance 10th grade I 2 should be filed w h and Mental Hygie 7 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Copeland Elzie Riggs ပ 19b. Mailing Address (Street and Number or Ryral Boute Number, City or Town, State, Zip Code), 969 North Hill Road Baltimore, Maryland 21218 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 Is Janice Randall/ Sister permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans Cem. Owings Mills, Md 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Md 21215 anso 23a. Part1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart filure. List only one cause on each line.

Immediate Cause i Final disease or condition resulting in death)

a. ADXC enception of the property of the condition of the condit Approximate Interval Between Onset and Death Physician Weeks /Medical Due to (or as a consequence of): Examiner Ardio-Dulmman if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 001005 Secretions Linonn Due to (or as a consequence of) physician Physician/Medical the as signed by the attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown me 1 ☐ Yes Completed CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Special Special Spe ဥ 1 Inpatient 2 ER/Outpatient 3 DOA o 24 hours after death.

e Funeral Director: After thi letely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

68760 o. ۵. Records, of Vital Division the Hospital or within 24 hou To the Fune completely fil

Baltimore, Maryland 21215-0036

State Registrar

H

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

and manner stated.

Bin C

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

6701

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

N. Charle St. Balto. Md

29d. Date signed (Month, Day, Year)

		-	Please	Type or Prin	nt in Bla EM#1 pe	ck Inde	elible Ink	Ensure A	II Copie: Mental Hy	s Are	<b>Legible.</b>	
		1 - State Registrar			-		ificate of			Reg. No		9 01.00
Dhuni		1. Decedent's Name	e (First, Middle, L	Abdur R	abman	Abdu	r Rahr	nan	2. Date of D Month	eath Da	ay Year	3. Time of Death
Physic /Med		ABNU	R	ACY	1110	47-56	71-		FEBRU		03, 200	7 / TUPM
Exam	iner			ive street and number)	7.0.70		0.	or Location of Death		40	c. County of Deat	h
Funera		5. Social Security N		Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth .	9. Birt	hplace (State or Foreign
Directo		217-01-	4846	1 X M 2 □ F	99	Yrs.	Months Days	Hours Min.			909	untry) NC
put		Usual Residence of	Decedent 10b. County		10c City To	own or Loca	tion					10d. Inside City Limits
Maryla f sho	Ď	MD	NA		, voc. o.ty, v		imore					1√2 Yes 2 □ No
r 28a	Director	10e. Street and Nur				7	10f. Zip Code			10g. Ci	itizen of What Co	untry?
th with	a D	4001 Cla	arks La	ne			2	1215			U.S.A	A •
r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13. Wa	as Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	pecity Yes or No Rican, etc.)	lo-	14. Race - Ame Black, White	
s afte	by Fi	1 ☐ Never Marri 3 ☑ Widowed	ied 2 Married	1, ∏Yes 2 ☐ I IFYes, Give Year or Dates:	No		∐Yes 2. XTNo				Specify:	
2 hour	led t		15. Decedent's E		1		nt's Usual Occup			16b. F	Kind of Business/	Black Industry
hin 72 ee.	Completed	(Spec		rade completed) College (1-4or 5	i+)	(Give kir life. DC	nd of work done NOT use retire	during most of world)	king			
illed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ant, the Marieu Examiran man be notified at		12th gra		na		Fork	Lift	Operator			stingho	ouse
intal Fedoral	B	17. Father's Name						18. Mother's Nam			n Surname)	
lal ylallu 2.12 2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	은	Hilton 19a. Informant's N			1	9b. Mailing	Address (Street				or Town, State, 2	Zip Code) 21207
Tand 2: Health a Health a tem 27 is other trau				s-Daughte								imore MD
es 1a of He rothe		20a. Method of Dis	position	☐ Removal from State			ion (Name of tory or other pla		Date		ocation - City or	
Pages ment of lant: If Ite		4 Donation	5 Other (Spec	ify)				ial 2/6,	/09	Syk	esville	e, Md
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Inforced Examination of the profiled at the profiled and the profiled at the profiled and the profiled at the profiled a		21. Signature of Fe	neral Service Lice	ensee	CAL	Ma	Name and Addre	H West				
- 202 %	1	23a Part1 Emer t	the disease or col	mplications that caused	the death F	43	<u>00 Wab</u>	ash Ave			re, Md	21215 Approximate
Dhysisian		shock, or hea Immediate Cause	art failure. List onl (Final	y one cause on each li	ne.				or respiratory	urrost,		Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death)		a. LARY Due to (or as			CATVE					
Examine		Sequentially list co	nditions	b								
ed sit	ine	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or as	a consequen	ce of):						
sxecut and	Examiner	that initiated events resulting in death)	5	c Due to (or as	a consequen	ce of):						
te be ex ysician e burial	-		•	d.								
ng ph	Physician/Medica	IF FEMALE:										
ath ce	ian/l	23b. Was deceden		23c. If yes, outcome 1 Live birth	2 Fetal de	ath 3 ☐ E	Ectopic pregnan	су			23d. Date of del Month	ivery Day Year
the de	ysic	1 ☐ Yes 2[ 9 ☐ Unknown	□No	4 ☐ Pregnant a 9 ☐ Unknown	t time of deat	h 5∐0	Other (specify) _					24,
s that ned by deta		Part II. Other signi	ficant conditions	contributing to death b		-	erlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
equires en sig	ed by	CHRON	1C K	10 NEY	DISEA	SE			10	]Yes 2	2 No 3 P	robably 4 Unknown
law re las be	Completed								24a. Wa	s an opsy	24b. Were au	stopsy findings available completion of cause of
The : The cate h	S								per	formed? 2 DN	death?	2 □ No
sician certifi	a	25. Was case referexaminer?		Hospital:			Ott	26. Place of Dea				
Physer this	7: To	1 Yes 2 2 27. Manner of Deat		1 ☐ Inpation	ent 2 ER	Outpatient b. Time of	3 ☐ DOA ☐	her: 4 Nursing H	ome 5 ☐ Res 28d. Describe	sidence how init	6 ☐ Other (Spe	cify)
affe. Affe	ation	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	( <i>M</i> o <i>nth, D</i> a	y, Year)	Injury	Wo	rkí? ]Yes 2 □ No			,	
r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	a   28e. Place of inj	ury - At home c. (Specify)	, farm, stree	t, factory, office		28f. Location	(Street a	and Number or Ru	ural Route Number,
urs aff												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)	1 ☐ Certifying F 2 ☐ Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination	dge, death o and/or inve	occurred at the t estigation, in my	ime, date and place opinion, death occu	e, and due to the crred at the time	ne cause( e, date ar	(s) and manner as nd place, and due	s stated. e to the cause(s)
To the within To the compl	Me	29b. Signature and			0		29c. Licen	se number		29d. Da	ate signed (Mont	h, Day, Year)
			,	relin n	nd		U3	0272		FE	BRUNNY	03, 2019
10		30. Name and add	ress of person wh	o completed cause of completed cause of completed cause of complete cause of cause cause of cause cause of cause cause of cause caus	leath (Item 23	Ba) (Type, Pr	int)					
VV	toto	31. Date filed (Mor	THI CUER	32 Registr	ar's Signature	+V670/	somev.	API, BAT	Much	E, M	MEYLAN	812120
S Regis	tate trar	560	1 1 9000	A	1	backe	1					
	-		2003	No.	10. 19	- 44 a						

DHMH 17 Rev 1/2001

RESPIRATORY

Due to (or as a consequence of):

**Physician** /Medical Examiner

Immediate Cause (Final

resulting in death)

the Hospital or Attending Physician: The law requires that the death certificate be executed

attending physician and for use as the burial-tran within 24 hours after death.

To the Funeral Director: After the

P.O. Box 68760.

Division of Vital Records,

Completed by Physician/Medical Examiner Be Medical Certification: To

O - e si - li - li - t disi	DIRONE				2	DAYS
Sequentially list conditions, if any, a district the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of 6	al death 3 🗆 Ectopic			23d. Date of delivery Month Day	Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.		o use contribute to the ca	4√ Unkn
-				autopsy performed? 1 □ Yes 2 ☑ N	prior to comple death?	tion of cause
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3 🗆 [	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) on	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Ro te)	ute Number,
29a. Certifier 1 Certifying P	hysician: To the best of my kno miner: On the basis of examina	owledge, death occurre	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as state	d. cause(s)

29c. License number

EASTERM

RE1-000

FAILURE

HOUR

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BALTIMORE

2009

21224

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To the Hospital within 24 hours a To the Funeral C

State

DHMH 17 Rev 1/2001

MARTINSON

29b. Signature and title of certifie

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral infractor, page 2 should be detached for use as the burial-transit

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

ဥ

Examine

Physician/Medical

þ

Completed

Be

Medical Certification: To

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Invited Explicit menual by neither an

and Mental Hygiene.

Department of Health a Important: If Item 27 is any injury or other tra once.

**Physician** 

the Maryland

death with

72 hours after

Baltimore, Maryland 21215-0036

/Medical

•	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown		opic pregnancy er (specify)	23d. Date of delivery  Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Coronary Artery I	Disease, Renal Insuffic	iency	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Failure to Thrive	2		24a. Was an autopsy performed? 1 □ Yes 2 ☒ No  24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Death	
examiner? 1 ☐ Yes 2 🎇 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Hom	ne 5□ Residence 6 MOther (Specify) Hospice
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Work?	8d. Describe how injury occurred
3 Suicide 6 Could not be determined		actory, office	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)  1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a pation, in my opinion, death occurre	and due to the cause(s) and manner as stated.  It is due to the cause(s) and due to the cause(s)
29b. Signature and title of certifier	) ^	29c. License number	29d. Date signed (Month, Day, Year)
	KI M.D.	P0065 02	24 02/08/09

6001 Muncaster Mill Road, Rockville, Maryland 20855

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

60

MA

2. Registrar's Signature

QUE

Year)

1

MONI

FEB

31. Date filed (Month, Day, FEB 1

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:40 AM onne Shaw /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death 4c. Examiner Baltimore uyland Medical ltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State of Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🗷 F Min. **Director** nau infant Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminar many. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√Yes 2□No **Funeral Director** MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4602 Furley Avenue 21201 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: Completed by black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Shaw Quaniesha Moore ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 S. Greene Street Baltimore, MD University of MD Med Ctr 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other (Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part \ Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner mamnic Sequentially list conditions Examiner r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) I or Attending Physician; The law requires that the death certificate be executed after death. and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 **№** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Director: filled in by thin 24 hours a

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Univof Mary

31. Date filed (Month, Day, Year)

and manner stated.

Center

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

land Medica

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1316081722

Emily Corrigan

29d. Date signed (Month, Day, Year)

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Funeral Director		5. Social Security N 220-24-2 Usual Residence of	129	6. Sex_ 1 <b>X</b> M 2 □ F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Months I	Year Days	Hours Min.	8. Date of Bi (Month, D July 6	year) 9. Birthplace (State or Fo. Country) Maryland			e (State or Foreign and
Maryland a-f show	ctor	10a. State Maryland	10b. County Anne A		10c. Cit	ty, Town or Lo		en Bu	rnie				- 1	Inside City Limits
ath with the s 23a or 28 rust be no	eral Director			ardrop Way,	Unit 101		10f. Zip C	210				itizen of What USA		
burs after death with the Marylan rain or items 23a or 28a-f show	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Mari</li><li>3 ☐ Widowed</li></ul>		rried Armed F	2 □ No ive	1	Was Deceder If Yes, specify 1 □Yes 2[		panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - A Black, W Specify:	hite, etc.	Indian, hite
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural", or items 23a or 28a-f show ent, the Marital Examiner rust be neithed at	Completed	(Spe	cify only highe	nt's Education est grade completed, College	) (1-4or 5+)	(Give	dent's Usual ( kind of work DO NOT use Carpente	done du retired)	ion Iring most of wor	king	1	(ind of Busine		ry
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and 2 shou ealth and N n 27 is mar er traumat		19a. Informant's N Patricia A			on)				nd Number or Ru ny, Unit					
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innortant: If item 27 is marked other than "natural", any Injury or other traumatic event, the "hourstell Exponee.		4 ☐ Donation	☑ Cremation 5 ☐ Other (S		State Ba	Place of Dispo cemetery, crem yview Cr	natory or other ematory	, Inc	2/11	•	Balt	ocation - City	⁄aryla	and
perm Depa Impo any I		21. Signature of Fi	1	r complications that	n E Ecker  caused the deat	2	37 E. Pa	ataps	of Facility MCC SCO Ave.,	Baltimor	e, Mo	1. 21225	5–1856	
Physician /Medical		shock, or hea Immediate Cause disease or condition resulting in death)	(Final	-	each line. 14NANT (or as a conseq	NEOP uence of):	LASM	CEI	REBRUN					erval Between set and Death
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te be executed ysician and e burial-transit	cal Examiner	that initiated events resulting in death)	S	*	(or as a conseq		LIO >CLE	ROTL	i cardio	VASLULAF	5 DZ	SEASE		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	? months? □No	23c. If yes, ou 1 ☐ Live	atcome of pregna birth 2□ Feta gnant at time of d nown	ildeath 3 ⊑	] Ectopic prec ] Other <i>(sp</i> ec					23d. Date of Month	delivery Day	y Year
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slcian certifi rector,	Be	25. Was case refer examiner?		Hospital:				Other:	26. Place of Dea					
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Ital or Atte irs after degral Director lied in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	nined 28e. Place	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, stre y)	eet, factory, of	ffice		28f. Location ( City or To	Street ar wn, State	nd Number or e)	Rural Ro	ute Number,
the Hosplin 24 hout the Funer the Funer mpletely fill	Medical	29a. Certifier (Check only one)	2 Medical		e best of my kno pasis of examina nner stated.	wledge, death ition and/or inv	estigation, in	my opir	nion, death occu	, and due to the rred at the time,	date an	d place, and d	ue to the	e cause(s)
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Sta Registra	te ar	31. Date filed (Mon	th, Day, Year)	2009	legistrar's Signa	ture Sa	Kel							

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Melissa Ann Spielberg	Dhyninia		1- For State Certificate of De			Reg	J. No.	
Count Security Processors    Count Security County   Coun			Melissa Ann Spielberg	<u>.</u>				
233-92-7137   M. (Xe)   30   Try   Months   Case   Heurs   Mn   July 11, 1978   Foregroup   December   July 11, 1978   Foregroup   December   July 11, 1978   Foregroup   July 11, 1978	,		4213 Old Milford Mill Road Pik		r Location of De	aut		
The content of the			213-92-7137 30 Yrs. Mc					
The control of the	<u>*</u> .	_	10a. State 10b. County 10c. City, Town or Location	lle				10d. Inside City Limits 1 X Yes 2 No
The state of the s	the Maryla 3a or 28a-f				1208	10	-	
Date of Disposition  The Proposition of Disposition	er death with	,	1 Never Married 2 Married Armed Forces? If Yes, sp	ecify Cuba	in, Mexican, Pue		White, etc.	
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Date of Disposition  The Proposition of Disposition	D 21 should be and Men 7 is man							1
Plysician Medical Cause (Final disease, ac completed cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only, one cause on each line.    Plant	ages I and 2 nt of Health at: If item 2	,	20a. Method of Disposition  Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition crematory or other placement.	(Name of c	emetery,	Date	20c. Location - City of	or Town, State
Plysician Medical Cause (Final disease, ac completed cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only, one cause on each line.    Plant	Saftin ermit. P. epartme nportan ijnry or		21. Signature of Funeral Service Licensee Dorota Marshall 22. Name	and Addre	ss of Facility  Cremat	ion Servi	ces	
Tailure. Large of personal manufacture cause (Final disease on each line. Death condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  Sequential	45		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo	Box 1 ode of dying	413, Ba g, such as cardia	Itimore, I	MD 21203 est, shock, or heart	Approximate Interval
Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause over injury that initiated events resulting in death) Last of Due to (or as a consequence of):    Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause over injury that initiated events resulting in death) Last of Due to (or as a consequence of):    Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause over injury that initiated events resulting in death) Last of Due to (or as a consequence of):    Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause over injury that initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause or injury list initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause or injury list initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause or injury list initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions or injury list initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions or injury list initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions or injury list initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions or injury list initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions or injury list initiated events resulting in the underlying cause given in Part I.    Sequentially list conditions or injury list in part in the part of the cause of death of the cause of list in the cause of list			Immediate Cause (Final disease a Diphenhydramine, tram	adol,	and tr	azodone i	ntoxicatio	
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West and the second of the sec		mine	cause. Enter Underlying Cause (Disease or injury that initiated					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of	cuted ransit		d.	07.0	0 6		0.0105100	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of	6 be exe	edica	ZZ /WILLIAM	,2/,2	.8a−1, p	ermE, g88		
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  February 9, 2009  Pamela E. Southall, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	on of \ ending Phy ath. or: After the	-	27. Manner of Death  1 Natural 5 Pending FD 2/8/09 FD 3:00 r				now injury occurred	
Assistant Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  February 9, 2009  30. Name and a ldress of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Divisi pital or Att ours after de eral Direct	Sertifica	Suicide 6 X Could not be determined (Specific) 1 Specific 1 Specific 1 Specific 28e. Place of Injury - At home, farm, street, far house	ctory, office	building, etc.	28f. Location (S or Town, S Pikesvi	Street and Number of P tate) 4213 Mi 111e, MD	Rural Route Number, City Llford Mill
296. Signature and title of certifier  O.C.M.E.  February 9, 2009  30. Name and a Idress of corson who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	the Hos hin 24 h the Fun		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, i	it the time, n my opinio	date and place, on, death occurr	and due to the caused at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	No.	Mec	and manner stated.	29c. Licer	nse number	_	29d. Date signed (A	fonth, Day, Year)
	John			enn Stre	et, Baltimore	e, MD 21201		
Registrar FFR I I 2009 Keeping P. 7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Elizabeth Guilielma Schmidt 9 2009 February 1:32 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. E November 30, 1917 9. Birthplace (State or Foreign Country)
17 Maryland 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min. Days 1 □ M 2 🛛 F 212-10-5110 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it at the first Even in at must be rediffed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Apt 3304 8813 Walther Blvd. 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>yr's</u> <u>Charge Nurse</u> <u>Hospital</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris George Havden Desdemonia Renes မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Lane - Daughter 1025 Lucabaugh Mill Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 12, 2009 Towson, Maryland <u> Hilltop Service</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21214 LA VIII GOL Leonard J. Ruck. 5305 Harford Rd Inc. 23a. Pirt 1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in inch line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to peath but not resulting in the upderlying cause given in 23e. Did tobacco use contribute to the cause of death? 2 2 1 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 1No 1 ☐ Yes 2 **HN**0 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1∐Yes 2∐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 6 Other (Specify) Certification:

Physician: The law requires that the death certificate be executed Box 68760, P.0. Records, Division of Vital the Hospital or Attending After Director:

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

State Registrar person who -mpleted cause of death (Item 23a) (Type, Print)

e Funeral

within 2

Medical

29b. Signature

31. Date filed (Month, Day,

and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

	1 = For State Registrar	otato or mary		epartment of I C <i>ertificate of</i>		, ,	eg. No. 200	9 04011
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dical	Louis Peter	Sicola				February	<u>/ 10, 2009</u>	5:25 AM
niner	4a. Facility Name (If not institution, g	oice Center			or Location of Dea	th	4c. County of Dea	
al	5. Social Security Number 6	Sex 7. Age (In	yrs. last birth					ltimore rthplace (State or Foreign
or	153-12-5745	1 <b>X</b> M 2□ F	90 Y	rs. World's Days	Tiouis Will	10-09-19	918 Ne	w Jersey
To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c	City, Town	or Location				10d. Inside City Limits
cto	New Jersey Huds	son		Jersey Ci	itv			1 X Yes 2 □ No
Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	
eral	77 Corbin Avenue	12. Was Decedent Ever i	2116	12 Mas Desertant of I	07306	Danife Was an No	U.S.	
Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Forces?	n u.s.	<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	pan, Mexican, Puei	to Rican, etc.)	14. Race - Am Black, Whi	
2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	IΙΙ	1 □Yes 2 🔀 No	Specify:		Specify:	White
etec	15. Decedent's (Specify only highest of		1 (	Decedent's Usual Occu Give kind of work done	during most of wo	orking	16b. Kind of Business	s/Industry
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5	Louis Sicola				Madeli	ne Brunc	)	
	19a. Informant's Name/Relationship Mrs. Geraldine Si	(Type. Print)	19b. 1	Mailing Address (Street D1 Argonne			City or Town, State, Marylan	
	20a. Method of Disposition			Disposition (Name of	1		20c. Location - City or	
	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from State	cemetery	crematory or other pla Service (	Corp. 02/1		owson, Mai	
	21. Signature of Funeral Service Li	,,		22. Name and Addre	ess of Facility	Ralti	more Mar	vland 2121/
N N N N N N N N N N N N N N N N N N N	Charles J. 1	River fr.		Leonard J.	Ruck, I	nc. 5305	Harford Ro	oad
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the cly one cause of each line.	leath. Do no	t enter the mode of dyi	ing, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. PNEUM						WEEKS
1		Due to (or as a con			NISTAG	٤		DERMES
Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence of	1 LUNG	0100101		The state of the s	DECHUES
xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ASBEST	DS	EXPOSUR	t			DELADES
Ιш	resulting in death) Last	Due to (or as a con	sequence of	):				
dica		d				· · · · · · · · · · · · · · · · · · ·		
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		·			23d. Date of de	elivery
sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		Month	Day Year
Phy	9 Unknown  Part II. Other significant conditions		roculting in t	ho undorlying cauco di	uon in Port I	23e Did tob	acco uso contributo t	o the cause of death?
d by	END-STAAT REN	AL DISEASE	roodining iir i	no underlying oddoc gi	voiriir r dit i.	1 <b>℃</b> Ye		Probably 4 Unknown
Completed	CORRECTOR A	LTEMY DISEA	1-05-			24a. Was ar		utopsy findings available
dmo	LUNCON HINDY HI	012104 01021	SE			autopsy	prior to death?	completion of cause of
Be C	25. Was case referred to medical examiner?				26. Place of De	1 □ Yes 2 ath (Check only one		s 2 No
10	1 ☐ Yes 2 🔀 No			atterit 3 1 DOA			nce 6 Other (Spe	ecify) HCSPICE
ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea	r) 28b. Tir Inj	ury Woi	rk?	28d. Describe ho	w injury occurred	
ficat	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	ho	At home, farn		Yes 2□No	28f. Location (Str.	reet a <i>nd Number</i> or Fi	'ural Route Number
Certification:	4 Homicide determine	28e. Place of Injury - A building, etc. (Sp	ecify)	,		City or Town	, State)	
Medical (	29a. Certifier  (Check only  (Check only)  Certifying  Medical Ex	Physician: To the best of my aminer: On the basis of exam	knowledge,	death occurred at the t	time, date and plac	e, and due to the ca	ause(s) and manner a	as stated.
1 20	one)	and manner stated.		3		and the state of t		(0)
ē	29b. Signature and title of certific	3		29c. Licens	no mumb c :	1	d. Date signed (Mon	th Day Vacai

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OANIEUX DV BLAMAN, MD 65U5 N WARLES ST, SWITE 209 BALTIMORE, MD 21204 2. Registrar's Signature

29c. License number

D64395

29d. Date signed (Month, Day, Year) FEBRUARY 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 04012 Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Voar **Physician** 2:15 PM M Solveig Marie Salvino February 9, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Derwood Montgomery If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1 □ M 2 🔀 F 93 471-24-2553 03/19/1915 Director ND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Indoordant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancher must be notified at once. 1 ☐Yes 2 No Director MD Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20895-4108 Byeforde Ct. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify: þ 3 M Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical Elementary/Secondary (0-12) College (1-4or 5+) Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Gottfried W. Callerstrom Bergine A. Gilbertson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William J. Salvino/Son 4108 Byeforde Ct. Kensington, MD 20895-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Feb 2009 Beltsville, Maryland 4 Donation 5 Dother (Specify) Chesapeake Crematory 22. Name and Address of Facility M00382 Styple & Loke Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RED Lince disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner day leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 🖼 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

24 hours a within 2 the

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

JENEVIEVE



completed cause of death (Item 23a) (Type, Print)

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

44615

PICCARD DR

29d. Date signed (Month, Day, Year)

MO

ROCKVILLE

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 4:15 PMM February 7, 2009 Marion L. Sturm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Asbury Methodist Home Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Months 1 M 2 X F 95 05/02/1913 NY Director 056-09-4266 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show ed other than "natural", or Items 23a or 28a-f show event, the "Actical Examinating be notified at 1 □Yes 2 X No Director Gaithersburg MD Montgomery death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20877-301 Russell Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after a ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Iten 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Specify: þ White 3 ⋈ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Administration Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Goeller John B. Leuthner ပ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5240 Ilex Way Dayton, MD 21036-Robert A. Sturm/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or of once. Feb 11 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licens m00382 Rapp Funeral & Cremation Services Rapp Funeral & Cremation Serv 933 Gist Ave. Silver Spring, 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death e heart ailure Immediate Cause (Final **Physician** /Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending properties for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Day Year Month 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Tim. OL 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy Sypertensin. 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation n 24 hours after death. e Funeral Director: Af bletely filled in by the fur 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier 04115 KIN

Registrar DHMH 17 Rev 1/2001

State

CACTHERSBURG, MAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSCLL AUENIUE

32, Registrar's Signature

W. RUBERT BIRSCHBALLI, WIA,

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

			For	State of Maryland / D			d Mental		2009	01.011.
		1	State Registrar		Certificate	of Death	2. Date of	Reg. No.	200.	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last) BEATRICE - T.	SCHILLING			2. Date of Month	n Day	3 2 Year	702:07PMM
	/Medic	-	4a. Facility Name (If not institution, give str	eet and number)	4b. City, Tow	vn, or Location of D			County of Death	1
	Examine	er	GOOD SAMAR		TL B	ALTIMO	RE		N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir	rthday) If Under 1 Y		Min. (Mont	h, Day, Year)	Con	nplace (State or Foreign untry)
	Director		219-22-1337	120/ 82.	Yrs.		SEPT	. 25,19	926	MD
7	2 >		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location					10d. Inside City Limits
27.00	shov	5								1∭XYes 2☐No
No di	28a-f	Director	MD N/A  10e. Street and Number	BALT	IMORE 10f. Zip Co	ode		10g. Citi	zen of What Co	untry?
with	a o a		4501 FRANKFORD AVE		212	206		τ	JSA	
thook	ms 2	Funeral		. Was Decedent Ever in U.S. Armed Forces?	13. Was Deceden	t of Hispanic Origin Cuban, Mexican, F	n? (Specify Yes Puerto Rican, et		14. Race - Ame Black, White	
3-UUSO 72 hours offer death with the Maryland	"natural", or items 23a or 28a-f show		1 Never Married 2 Married	1 ∐Yes 2 ∭XNo If Yes, Give	1 🗆 Yes 2 🖸				,	WHITE
3-00-c	Fra!;	d by	3 Widowed 4 Divorced	Year or Dates:	when the same and			16h Ki	nd of Business/	Industry
ָהְ קַּי		Completed	15. Decedent's Educa (Specify only highest grade		a. Decedent's Usual C (Give kind of work of life. DO NOT use r	done during most o	f working	100.10	nd of Buomioson	modery
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ט פ	Hygi Hygi Sther ent, t		17. Father's Name (First, Middle, Last)				Name (First, M	liddle, Maiden	Surname)	
and Gha	hental ked c	To Be	JOHN THOMAS SCHILL				MARIE H			
ary	smulto be lifed within and Mental Hygiene.  Is marked other than aumatic event, It is in the	-	19a. Informant's Name/Relationship (Typ	' ' I	b. Mailing Address (S					
, Ma	3 <del>5</del> 5 5		JOHN BOYCE SISOLAK		7905 E. I		Date		RE, MD	
e .	ges I and z should be lifer it of Health and Mental Hygis if Item 27 Is marked other or other traumatic event, It		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Ref	moval from State cemete	of Disposition (Name ery, crematory or othe	er place)			-	
	tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)	UAKL	AWN CEMETI	EKY	2/12/09		LTIMORE	L HOME, INC.
Baltimo	permit. Fages I am Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral, ervice License	•		ELAIR RD			MD 212	
			23a. Part 1. Enter the disease, or complic	ations that caused the death. Do	not enter the mode	of dying, such as ca	ardiac or respira	tory arrest,		Approximate Interval Between
	hydiolan		shock, or fleart failure. List only one Immediate Cause (Final	SEPSIS.						Onset and Death
	hysician /Medical	ı	disease or condition resulting in death)	Due to (or as a consequence	e of):					
E	Examiner	ı	b	PNEUMON	IA, COMI	MUNITY	ACOUIR	ED.		20hors.
-	, ±	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):					201013.
8.	and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence	e of):					
<i></i> €0,09	icate be executed physician and the burial-transit	a E		(**						
687	phys the	edical	d							
Box	leath certific attending p	N/U	IF FEMALE: 23b. Was decedent pregnant	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3□ Ectopic pre	anancy			23d. Date of de	
ň	deatr le atte ed for	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of death					Month	Day Year
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Ś.	irres that signed I d be deta	þ		umonale.	in the underlying can	ase given in trait.				robably 4 Unknown
0.0	w requires been signal and a	Completed	- <del> </del>				242	. Was an	24b. Were a	utopsy findings available
3e	e law has l	큩			·		-	autopsy performed?	prior to death?	completion of cause of
<u></u>	Physiclan; The lav this certificate has al director, page 2:		25. Was case referred to medical			26. Place	of Death (Check	Yes 2 N	o l 1∟l Ye	\$ 2 LVA0
5	/sicla s cert directo	o Be	evaminer?	ospital: 1 Dipatient 2 ER/0	Outpatient 3 DOA	Other: 4 Nur	sing Home 5	Residence	6 ☐ Other (Sp.	ecify)
o c	g Phy ter thi	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b	o. Time of 28	c. Injury at Work?	28d. De	scribe how inju	ry occurred	
<u>ö</u>	endin ath. or: Af	atio	1 Accident 5 Pending investigation		M	1 ☐ Yes 2 ☐ N	1			
Division of Vital Records,	or Atto	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory,	office	28f. Loc City	ation (Street a or Town, Stat	nd Number or F e)	Rural Route Number,
Ω	oital o		29a. Certifier 1 ertifying Physical Phy	sician: To the best of my knowled	ige death occurred a	at the time, date an	d place, and due	e to the cause(	s) and manner	as stated.
	Hos 24 ho Fun etely 1	Medical	(Check only 2 Medical Exami	ner: On the basis of examination	and/or investigation,	in my opinion, deat	th occurred at th	e time, date ar	ia piace, and oc	le to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	29b. Signature and title of certifier	SILVAVONA	<b>1</b> 29c.	License number		29d. D	ate signed (Mor	nth, Day, Year)
	->-0		Simalumal	N NARAYANAN	, MD !	RES 000	0		02/08/	09.
	m		30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type, Print)	n 0.		Horas	560	OI LOCH RAVEN
	18		SHIVAKUM	ARO NARAYAN	VAN GOO	DD -SAMP	KITAN	FIOSPIT	AL, DLV	21239.
	St Regist	tate trar	29b. Signature and title of certifier  30. Name and address of person who compared to the second sec	Sz. negistrar szsignature	V (14 CM					

Amend 20a-c, per FH g888 2/18/09 TT
Please Type or Print in Black Indelible ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Death

State of Maryland / Department of Death 04015 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician SMITH ORIN SAM 4:05 February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 6. Sex 1 🗶 M 2 🗆 F If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 02/25/1948 220-56-3334 60 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at BALTIMORE OWINGS MILLS BALTIMORE MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA 164 SPECTATOR LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year, or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married WHITE than "natural", or 1 ☐ Yes 2 No Specify: Specify 2 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medion... Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( **SMITH** BESSIE RODNER BERNARD 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 164 SPECTATOR LANE, OWINGS MILLS, MD LINDA SMITH / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)

Beth Triloh Cemetery 02/10/2009

20c. Location - City or Town, Some MD

22c. Name and Address of Facility

20c. Location - City or Town, Some MD

Townson MD

Baltimore, MD

22c. Name and Address of Facility 20a. Method of Disposition 20c. Location - City or Town, State 1 Daurial 2 Coremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mars 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5eps15 Physician /Medical Due to (or as a consequence of): peripheral vascular disease Examiner severe Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deatle Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) completely the ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00051347 Cynthia small W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Solamb My 670,1 N. Charles St Baldimore MA 21204

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

32. Registrar's Signature

A STATE OF THE PARTY OF THE PAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 10:55PM <sup>™</sup> Frank Gilroy Stoner February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Bethesda Brighton Gardens Montgomery 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 ☐ F Yrs Director Philippines 89 June 27, 1919 230-12-2146 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State ed other than "natural", or items 23a or 28a-f show event, the thedical Examinator is ust be motified at 1 ☐ Yes 2 No Directo Rockville <u>Maryland</u> Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 9 Orchard Way North 20854 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. XYes 2 □ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: à Specify. 3 X Widowed 4 ☐ Divorced WWII White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.
Int: If Item 27 is marked other than U.S. Secret Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Item 27 is marked or r other traumatic eve ٩ Frank E. Stoner Deah Gilroy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deanne Smith/ Daughter Orchard Way North, Rockville, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State February 4 ☐ Donation 5 ☐ Other (Specify) Alexandra, Virginia Crematorium 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Furteral Service Licenses M00335 23a. Part 1, Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Failure to Thrive /Medical Due to (or as a consequence of) Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy performed death? 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 🗆 Na To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Living Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier NX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

Registrar

DHMH 17 Rev 1/2001

State

84

29b. Signature ar

Ajay Reddy,

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

M.D.

29c. License number

D53691

3200 Tower Oaks Boulevard #10010 Rockville, Maryland 20852

29d. Date signed (Month, Day, Year)

February 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Quinta D. Sabatini February 4, 2009 7:55PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N. Betnesses

If Under 1 Year If Under 24 Hrs.

14 and the Days Hours Min. Brighton Gardens Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex Months 1 □ M 2 🕅 F 577-03-7979 Director 90 August 25, 1918 Italy Usual Residence of Decedent 10b. County show 10a. State 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery N. Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 5550 Tuckerman Lane Suite 352 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕅 No If Yes, Give Year or Dates: Specify: þ Specify: 3K Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Alfred Desideri <u> Matilda/ Unknown</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alex C. Sabatini/ Son 4829 Piney Branch Road, Fairfax, Virginia 22030 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Februar 4 ☐ Donation 5 ☐ Other (Specify) 20, 2009 National Cemetery Arlington, Virginia 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fuperal Service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Brain Tumor /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions ner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami sician and burial-trans <u>Diabetes Mellitus</u> Due to (or as a consequence of): attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical <u>Dementia</u> 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ā No Month 4 ☐ Pregnant at time of death 5 Other (specify) detached f Ö 9 DUnknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1∐Yes 2⊠No 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living examiner? 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

the within 2 To the I 2 D

> State Registrar

29b. Signature and title of certifier

Rita Gosh,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14804

M.D.

FFR 1 1 2009

Physicians Lane,

32 Registrar's Signatur

29c. License number

D30132

#221 Rockville, Maryland 20855

29d. Date signed (Month, Day, Year)

February 6, 2009

09-01089 Julia Smith			Print in Black In		•	_	ible.	
Julia Sittiut		SIBIE C For State Registrar	f Maryland / Depa <i>Cer</i>	artment of Hea tificate of Dea		-	, No. 200	19 0401
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle Last)	nith			2. Date of Death Month February 6	Day Year	3. Time of Death 0617 hrs
		4a. Facility Name (if not institution, give Johns Hopkins Hospital	street and number)		, Town, or Location of Dea		4c. County of Death	
Funeral Director	C	5. Social/Security Number 6. Sex 14-84-6511	7. Age (In yrs. l.		nder 1 Year If Under 24H	1 01	Foreign	nplace (State or )
any	F	Usual Residence of Decedent  10a. State 10b. County	10c Gity,	Town or Location				10d. Inside City Limits
ryland sa-f show	Director	10e. Street and Number 1	DI	41t1/WE(	Zip Code	10	g. Citizen of What Coun	1 Yes 2 No
th the Ma 23a or 28 motified 2	Dire	1206 VAILEY	St.		2/202/		U.5, F.	7
after death with the Maryland "c". or items 23a or 28a-f show any incr must be notified at once.	F, Funeral		12. Was Decedent Ever in U Armed Forces 1 Yes No f Yes, Give Year or Dates:		dent of Hispanic Origin? ( cify Cuban, Mexican, Puer  No specify:		14. Race - Americ White, etc.	ACL
36 in 72 hournan "natu lical Exan	ompleted	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)		al Occupation (Give kind of vorkin, life, DO NOT use r		16b Kind of Siness/Ir	ployed
D 21215-C036 should be filed within 7 nd Mental Hygicine is marked other than atic event, the Medica	Be Co	the s Name (First, Middle Last)	ith		18.Mother's Na		aiden Sylhame)	
MD 21 d 2 should 1 lth nd Mer n 2 is man umatic ev	의	1 % II foint' Name/Relatio sh	COHF SI.	19b. Mailing Addre	ssi She Ind Number of	Rural Route lumi	City or Town, tate,	Zip Coole 21/2/2/2/
altimore, MC mit Pages 1 and 2 si no ment of Health 1 per tant: If item 2 jury or other 1 and	83	20 ethod of Disposition  Burial 2 Cremation 3  Donation 5 Other Specify:	Removal from State	Place of Disposition (Northwest place	lamelof cemetery,	-13-04	20c. o lation - City or	Tow , State
Balti permit Depa m impo. t		11. Signature of Funeral Service Licens	MMN	22 Name at	nd Address of Facility	ATERIA.	By Wills	7/3/
Physician /Medical		3a. Part I. Enter the disease, or complication. List only one cause on each	h line.			or respiratory arre	st, snock, or heart	Approximate Interval Between Onset and Death
xaminer		Part	Narcotic and ue to (or as a consequence of		toxication			Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence o	of):				
tted Jansit	Examiner	(Disease or injury that initiated C.—	ue to (or as a consequence o	of):				
	_ 1	X UNPENDED	AMENDED 23a,27,	28a-f, per	ME, g889 3/1	13/09 TT		
8760, ificate bo	n/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	gnancy 2 Fetal dea	th 3 Ectopic pred	nancv	23d. Date of delivery	Day Year
Box 68760 e death certificate b the attending physical for use as the burner of the burner as the bu	Physician/Medica	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time of de	2				
P.O. E that the	by Ph	Part II. Other significant conditions	contributing to death but not r	resulting in the underlyi	ing cause given in Part I.		pacco use contribute to t	
Division of Vital Records, P.O. rate of certains that the radio death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed					24a. Was a	n 24b. Were aut	topsy findings available ompletion of cause of
Reco The law icate has	Comp					perform	med? death?	
/ital stcian: is certif	a	25. Was case referred to medical examiner?	ospital:	ER/Outpatient 3	26.Place of Death (Cher DOA Other, Nur		Residence 6 Other	
of V ng Phy After th	입	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
Sion Attendi death.	catio	1 Natural 5 Pending 2 Accident Investigation	Fd 2/6/09		1 Yes 2 X No	unk		- D N
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executifing a hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tri	Certification:	3 Suicide 6 X Could not b determined	28e. Place of Injury - At house		ory, office building, etc.	or Town, St BAltimo	treet and Number of Ru ate) 1206 Val re, MD	Ley St.
the Hos hin 24 hc the Fum	Medical C	one) 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a					
To To COM	Mec	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mor	nth, Day, Year)
		Mayorite me l	Krell		O.C.M.E.		February 7, 2009	
TIX.		30. Name and address of person who co	ompleted cause of death (Iten	n 23a)				

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

111 Penn Street, Baltimore, MD 21201

Margarita Korell MD. Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MONROE STULTZ MURWIN 2009 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARSTON CARROLL NEW WINDSOR If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 🕱 M 2 🗆 F Months Days 219-14-1389 85 Director July 11, 1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 X No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2922 Marston Rd. 21776 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1943–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No ģ Specify: Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 owner/operator burner service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas David Stultz ပ Fannie Hatfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennie L. Fugitt/ daughter P.O. Box 308 New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. James Cemetery 2/13/2009 Dennings, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licenses atharine 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) ACUTE Physician Renal /Medical Due to (or as a consequence of): Examiner WENK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by UlmonARY No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Rumas &

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3900 Local

32. Registrar's Signature

Koron

R046220

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#5&18perFH G888, 2/11/09 JIS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 905-AM DESSICA SHEPPARI 0% 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKING BAYVIEW MEDICAL CENTO, MORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 204-54-6858 1 □ M 2 KF Months Days Hours Min. Director 45 02/11/1963 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6319 Brown Ave 21224 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 → No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑No þ If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be <del>ሁለ</del>ሉ Julia Marie Madison ဥ Frank Sheppard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21224 Alton Graves/Husband 6319 Brown Ave. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 7 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2009 Beltsville, Maryland 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Peltimore, Maryland 211 Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final **Physician** Cancer cervica disease or condition resulting in death) 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Box 68760, burial-1 Due to (or as a consequence of): physician a Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page certificate 2 No 2 🗆 No 1 □ Yes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1∏Yes 2∏No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( Certification: To After the 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 T Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 D Homicide Within 24 hours a To the Funeral I 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day,

rossne,

Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns

Registrar's Signatul

Hopkins

29d. Date signed (Month, Day, Year) 09

Barview Medical Center

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 02-02-2009 9:25a Alle Thompson 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home 5. Social Security Number 6. Sex Baltimore er 1 Year | If Under 24 Hrs. If Unde 8. Date of Birth (Month, Day, Yes 09/15/1912 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 🛂 F 139-16-2462 96 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1X Yes 2 No N/A Gwynn Oak 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6745 Ransome Drive 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 XiNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: African American 3 X Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baker 2nd Bakery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Indiana Gist Mary Stroud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6745 Ransome Drive Gwynn Oak, MD 21207 Audrey Morton 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02-07-2009 King Memorial Park Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wolle Funeral Home P.A. ture of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PERTENSIV Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical been signed by the should be detached ģ Be Completed certificate has birector, page 2 sl Certification: To funeral ithin 24 hours after death.

the Funeral Director: A smpletely filled in by the fu

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is merked other than "natural", or items 23a or 28a-f show emportant: or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination that be notified at once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

29c. License number

DRIVE

within 2.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REISTERSTOWN

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

BUSINESS 32. Registrar's Signature

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17, perDVR#20a-c&22perFH, G900, 2/17/2010, WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2009 4:00 pm BABY GIRL TOLIVER January 26 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2√2 F Director 2 1/26/09 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Montgomery Director Maryland Silver SPRING 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 2348 RED EAGLE COURT 20906 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) N/A /Ainjury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk ٩ TAKETA TOLIVER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2348 Red Eagle Ct. Silver Spring, MD 20906 19a. Informant's Name/Relationship (Type. Print) Taketa Toliver (mother) permit. Pages 1 and 2:
Department of Health at
Important: if Item 27 Is
any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State 4 Donation 5 Hether (Specify) in State Evans Funeral Chapel June 24, 2009 Forest Hill, MD 21. Signature of Funeral Service Licensee Wade, Director State and Address of Facility and 655 W. Baltimore Street Raceful Alternatives 2325 York Rd. Timonium, Aff 21093 Part. In let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Previable birth /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Incompetent cervix Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s certificate has been signe irector, page 2 should be 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 🖵 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 🖵 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 D36129 1/26/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Samuel

31. Date filed (Month, Day, Year)

York Rd, Ste 14, Lutherville, MD 21093

1205

32. Registrar's Signature

Akman, M.D.,

State of Maryland / Department of Health and Mental Hygiene 04023 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year -26 algustat 200 12:07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Blakehurst Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 29 **Funeral** Year) Months 1 ☐ M 2 🗓 F Yrs. Director 1915 Jan. New York 043-38-6550 Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Baltimore 28a-f Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1055 W. Joppa Road, Apt. 643 21204 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify: Completed by Specify 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Woodbury W. Horace Louise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other trau once. 8304 Burning Wood Road Baltimore, Maryland Louise Kemper Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson Hilltop Service Corp.: 2-11-2009 Maryland reture of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart **Physician** cass /Medical Due to (or as a consequence of): Examiner orones Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mi Connell 32. Registrar's Signature 31. Date filed (Month, Day, Year) State back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar  1. Decedent's Name (First, Middle, Las	State of Marylar		rtificate of			3. No.	3. Time of Death
Physicia		Michae		. D.D.	S.		Month	2009 Year	8:20 A M
/Medic Examin		4a. Facility Name (If not institution, give		, 2020.		r Location of Death		4c. County of Dea	
_xa,iiii		Edenwa				Towson		Balt	timore
uneral		Social Security Number     6. S		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )		thplace (State or Foreign
irector		213-03-1286	<b>©</b> ™ 2□ F 9	O Yrs.	Months Days	110010	Mar. 2,		cyland
*		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty. Town or Lo	cation				10d. Inside City Limits
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28a-	rect	Md. Ba	Ltimore		TOWS	on	100	g. Citizen of What Co	ountry?
3a or		800 Southerly 1	Road #N-117		C 11 15	21286		USA	
liem 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, if a Modical Examinst must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	I.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
or Ite		1 Never Married 2 Married	1 Yes 2 No If Yes, Give		1 Tes, specify Cuba 1 □ Yes 2 🙀 No	Specify:	o Alcan, etc.)	Black, Whit	te, etc.
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arked other than atic event, tre M	щ	Elementary/Secondary (0-12)	College (1-4or 5+)	<i>iii</i> 6.				M- 44.	1
other ant. I		17. Father's Name (First, Middle, Last)	<del>JT</del>	.1	Dentis		ne (First, Middle, Ma	Medic	cat
Ked C	To Be	Frances	sco Ventura				Agata Li	ibertini	
aumat	-	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street	and Number or Ru		City or Town, State,	Zip Code)
other tra		Patrick Ventura/So	on	6825 (	Crofton C	olony Ct.	Crofton	n, Marylar	nd 21114
oth	1	20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	1		Oc. Location - City or	
ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐  • 4 ☐ Donation 5 🔯 Other (Specify	Dul	aney Va	alley Mem	. Grd. 2/	/13/09 Ti	imonium, M	Maryland
Important: If I any injury or o		21. Signature of Funeral Service Licer	911 11	22	2. Name and Addre	ss of Facility Ru	ick Towsor	n Funeral	Home, Inc.
<b>a</b> a		Michael	1/Luss		050 York			yland 2120	)4
ician dical niner	j.	23a. Part1. Enter the disease, or of shock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Action a Consection of the	el pero	(		Alshein	,	Interval Between Onset and Death
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completely tilled in by the funeral director,	edical Co	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exer	ysician: To the best of my kniner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	s stated. e to the cause(s)
to the Funeral Director: A completely tilled in by the to	Me	29b. Signature and title of certifier	1 1		29c. Licens		290	d. Date signed (Moni	th, Day, Year)
		Beach Book	tenth on		R13	3985	7	219105	
		30. Name and address of person who		m 23a) (Type,	Print)				
_ V		Brian Hock	cenomin co	MB &	co swi	herly Re	1, 70W	son, 170.	21286
Sta	ate	31. Date liled (Month, Day, Year)	32. Registrar's sign	ature		/	1	,	

/Médical Examiner Box 68760, P.O. Records, Division or Vital e Hospital or Attending 24 hours after death.

and burial-trar physician Physician/Medical the SS the þ Completed page 2 s certificate 2 this Certification: After t within 24 hours after death To the Funeral Director: completely filled in by the Medical

**Physician** 

/Medical

MD

Director

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Completed

Be

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than "

permit. Pages 1 and 2 s Department of Health ar

Important; If item 2 any Injury or other

**Physician** 

Maryland 21215-0036

Baltimore,

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 LNo 27. Manner of Death 1 🖎 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

RES OUU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SARAFVA ELENA 5601 LOCH RAVEN BLVD BALTIMORE, MD 31. Date-filed (Month, Day, Year)

State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM 299 PerDVR 6888 2/11/09 WS State of Maryland Department of Health and Mental Hygiene 2009 04027 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** 02 4:55 AM 2009 /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Multi Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Medical 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F Director 245-24-1209 82 9/18/1926 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Baltimore Direct Essex 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21221 962 Kinwat Avenue Α. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1∑Yes 2 □ No If Yes, Give 1945 Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Š Specify. 3 Widowed 4 Divorced 1946 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 12 Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be t and 2 should be fit Heelth and Mental H tem 27 is marked off Ranzy Webb Anita Burleson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth an important: If Item 27 ie m. any injury or other ones. 974 Homburg Avenue Sandra Bosse (Daughter) Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) 2/13 2609 Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Fundal Service Liesus 22. Name and Address of Facility

Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on-cause en each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Fever Iday /Medical Due to (or as a consequence of): Examiner b. Advanced dementia > 8 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by sete has been signification page 2 should be lerinary Retention 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown BPH 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 ho Pneumonia a Cdiff colitis 2 ENO 2 No 1 Tyes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifier (Check only 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

XNurse Practition (Practition (P 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after or To the Funerel Directorphiles of the Completely filled in by

> State Registrar

31. Date filed (Month, Day, Year) FEB 1 1 2009

Michelle E. Kalender CRUP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

R097104

29d. Date signed (Month, Day, Year)

2/10/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Williams В. Rebecca 2009 02 7:56p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8533 Stevenswood Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours Months 88 Director 215-16-2471 13 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Model Examination mast be notified at Director MD NA Baltimore 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 21244 U.S.A. 8533 Stevenswood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes &☐ No Specify: Specify: ੬ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, If et Pooling once. Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm. Clerk 12th Grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Burke Luther Burke ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3508 Lynne Haven Drive, Baltimore, Md 21244 Roger Burke-Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National: 2/13/2009 Laurel, Md 21. Signal re of Funeral Service 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** GANGRENO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Diahetic The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): I of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy certificate 2 No 1 □Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide P-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature ar 29c. License number HENDING M.D 17118

State

Registrar

Name and address of person

392 Newlan

who completed cause of death (Item 23a) (Type, Print)

M.D 32. Registrar's Signature

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Physicia /Medic		1. Decedent's Nam  Joseph L	. White	2								2. Date of D. Month Feb	eath 06	2009		e of Death
Examin Funeral	er	Carroll 5. Social Security N	Hospice	n, give street and nue  Dove Hou  6. Sex	ıse	e (In yrs. la	ast birthday)	West	mins	ster		8. Date of B	rth (	Carroll		ate or Foreign
Director		212-84-0	Decedent	1 <b>X</b> M 2□ F		44	Yrs.	Months	Days	nouis	IVIIII.	Jan 11	. 19	965   M	aryla	
he Maryla 28a-f shov	Director	MD	10b. County	511			esvil	le	- 0-1-				10-0		1 🗆	de City Limits Yes 2 No
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Martal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examiner must be notified at once.	Funeral Dir	10e. Street and Nur 2003 Che 11. Marital Status		12. Was Dec	edent l	Ever in U.S	S. 13.		784	ispanic C	Origin? (Sp	pecify Yes or No Rican, etc.)	US	SA  14. Race - Ame		n,
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and 2 shou eaith and N n 27 is ma ier trauma		19a. Informant's Name/Relationship (Type. Print)       19b. Mailing Address (Street and Number or Rural Route of Street and Number of Street											-		Zip Code)	
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Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List (Final on	a	each lir	a consequ	U 67	iter the mo	de of dyin	g, such a	as cardiac	or respiratory	arrest,		Approx Interval Onset a	Imate I Between and Death
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for the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  For the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 I 9 ☐ Unknown	! months? □No		birth gnant a	of pregna 2 ☐ Fetal t time of d	death 3	□ Ectopic □ Other (s		У				23d. Date of de Month	elivery Day	Year
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Physicia this certi al directo	To Be	25. Was case reference examiner? 1 ☐ Yes 2	]No	Hospital: 1			ER/Outpatie			er: 4 🗆			sidence	6 Nother (Spe	ecify) Do	e House
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To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:		4 ☐ Homicide  29a. Certifier	determ	nined 200. Flat build			me, farm, st			me date	and place	City or To	iwn, Stai			vumber,
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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

Amend #5 per Fh g889 3/24/09 Certificate of Death

Reg. No. 2 1 1 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Frances D. Wolff 10: 32 A M 02 2.009 07 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner are Hospital attimor ozeda If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye January 12, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 925 **Funeral** Days Months 219-14-0548 0948 1 ☐ M 2 ☐ F Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evantiner must be notified at Maryland M⊈Yes 2 ☐ No N/A Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5904 Point Pleasant Road 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ひっぱ FranceS Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. White þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Grocery Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Prietz Ella Machovec 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wayne Wolff/Son 1980 Hain Road New Freedom Pennsylvania 17349 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp. 2/12/09 Towson Maryland 122. Name and Address of Facility 5305 Harrord Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses frut Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -cranial Physician ntra disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit A PER certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02/07/2009 0005503 JOONANN) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD Franklin Jacques 31. Date filed (Mont Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 3 Val 2009 **Physician** FEB WILSON EDWARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Long Green Center - Genesis Baltimore
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Yrs 57 Director 218-54-3490 12/02/1951 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 Nes 2 No Director MD Baltimore 10e. Street and Number 10f Zin Code 10g Citizen of What Country? "natural", or items 23a or dical Examiner must be r 21211 2065 Druid Park Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the M Pepsi Cola Elementary/Secondary (0-12) College (1-4or 5+) Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked ၉ Edward Stolkey Wilson Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Edward Albert Wilson, Jr/Son 913 Lutz Avenue Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of I Important: If its any Injury or o 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Feb 10 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives itti 8717 Freen Pastures Drive Baltimere, Maryland 21286 ter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. En r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC disease or condition resulting in death) ANCER Month /Medical Due to (or as a consequence of) DIELENEMIA Examiner Sequentially list conditions, sequentially list condition that it, leading to transcate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed THRIVE PAILURE 70 physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes certificate 2 ☐ No 1□ Yes 2☑No Be ၉

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Be	25. Was case referred to medical examiner?		26. Place of Death (Check only	(one)			
0	1 Yes 2 V6	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: Nursing Home 5 Re	sidence 6 □Other (Specify)			
ation:	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation		28c. Injury at Work? 1 Yes 2 No	e how injury occurred			
Certific	3 ☐ Suicide 6 ☐ Could not be determined		ctory, office 28f. Location City or 7	(Street and Number or Rural Route Number, own, State)			
edical (		hysician: To the best of my knowledge, death occu miner: On the basis of examination and/or investig- and manner stated.					
Σ	29h Signature and title of certifier		29c. License number 29d. Date signed (Month, Day, Year)				

and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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DO053150 FEB 5 2009

30. Name and a Mress of person who completed cause of death (Item 23a) (Type, Print)

Sentrego Rd State 110 (dumbre 9650 Shakunmele 2 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2009 04032												
-			Registrar  1. Decedent's Name (First, Middle, La	ast)		er uncate or	Dealli	2. Date of Death				
	Physicia		Charles			Februar		11:51 &				
	/Medic Examin		4a. Facility Name (If not institution, gire	of	4b. City, Town,	or Location of Death	, 02, 00,	4c. County of Death				
أنجمي			St. Joseph Hospi	ital		Tows			Baltim	ore		
	Funeral Director		5. Social Security Number 213-28-8510	Sex 7. Age	(In yrs. last birthda 78 Yrs	Months Days		8. Date of Birth (Month, Day, July 2,	Birth Day, Year)  2, 1930  9. Birthplace (State or Foreign Country)  Maryland			
	pu. N		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Looption				10d. Inside City Limits		
1215-0036 within 22 hours after death with the Maryland	Aaryla f sho	o	MD Baltir		1 ∐Yes 2 ⊠No							
	r 28a-	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou			
	h with	al D	35 East Timonium Road			2	21093		U.S.A	•		
	72 hours after death with the Marylan "natural", or Items 23a or 28a-f show client Exprimer mant be notified at	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1	iver in U.S. 1	3. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🗶 No	Hispanic Origin? (Sp. ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	, etc.		
	n 72 hours n"natural",	eted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gr.	cedent's Usual Occu	upation	ing. 10	Specify: White  16b. Kind of Business/Industry					
		Completed	Elementary/Secondary (0-12)	College (1-4or 5-	F)		e during most of worki ed) Technicia		Genera	tors		
פַ	al Hyg other	a	17. Father's Name (First, Middle, Last	<u> </u>			18. Mother's Name			CO1 3		
yland	should be nd Mental marked o	To B	Albert C.	Zapf			Hel					
Mar	and 2 shealth and 2 shealth and 27 is ner traun		19a. Informant's Name/Relationship Veronica S. Zapi			-	nium Rd.,		City or Town, State, Z			
altimore,	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □		cemetery, c	position (Name of rematory or other pla Valley	ace)		Oc. Location - City or T			
aitil	permit. Popertime Important any injury once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Servic Lice						Funeral Ho			
מ	S E E G		MM			1050 York	Rd., Tow	son, MD	21204			
		ic 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on cool line.  Immediate Cause (Final									
	Physician /Medical		disease or condition resulting in death)	a. Due to or a	consequence of):	cerie	2/	/				
	Examiner	_	Sequentially list conditions,	b	p Cone	dial e	~ and	Tien	-			
	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	donsequence of):		ν						
Ď	an and rial-tra	Exa	that initiated events resulting in death) Last									
8/6U	cate be executed physician and the burial-transit	dical		<b>d</b>								
×	certific	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy				Ond Date of dali			
O. Box	requires that the death certifi een signed by the attending nould be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death	B ☐ Ectopic pregnan D Other (specify)			23d. Date of delivery  Month Day Year			
<u>,</u>	that the one of the one of the		Part II. Other significant conditions	co use contribute to the cause of death?								
Spac	equires en sign ould be	ed by						1 □ Yes	2 <b>₽</b> No 3 □ Pro	obably 4 ☐ Unknown		
S L	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was an autopsy performe	prior to o death?	opsy findings available ompletion of cause of		
	sian: J	Be C	25. Was case referred to edical 26. Place of Death (Check only one)									
0	Physician: this certific ral director,		examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
	ding F h. After funera	ion:	27. Manuel of Death  1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injur (Month, Day)	y 28b. Time ( <i>Year</i> ) Injur	/ Wo	uryat ork? ∐Yes 2 ∐No	28d. Describe how	injury occurred			
NSI N	r Atten er deat rector: by the	Certification: To	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm,	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,		
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	Nith Co	2	29b. Signature and title of certifier	nde/		29c. Licen	ise number	290	d. Date signed (Month	Day, Year)		
	h		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	e, Print)	ME RICEL	Y.M.D.	717	/		
	1,7 1		7505 OSLE 31. Date filed (Month, Day, Year)	ER DRIV	IE ST	E 103A,	Towso	N MD	21204			
	Sta Registra	-	FEB 1 1 2009	Seren N	A. A.	e, Print) A1 E 103A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #10e&19b Per Inf G8893/20/09 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 **Physician** JOAN MARIE ARTZ 28 2009 5:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 7. Age (In yrs. last birthday) 75 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 5/18/1933 1 □ M 2 1 F Months Days Min. Hours 162-28-5063 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Madical Experiment mast be notified at MD Director Worcester Berlin 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? River Run Lane 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 2 should be filed whand mand Mental Hygier Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic Paul Rhinehart Laura Stamm 19a. Informant's Name/Relationship (Type. Print) Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Artz / husband River Run Lane, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 1/28/09 Frankford, DE 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Burbage Funeral Home <u> 108 William St.,</u> Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown <u>a</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Vital 1 □Yes 2 No 1 ☐ Yes 2 ☐ No ; After this certifical e funeral director, p Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA oto 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending To the Hospital or Augustin Within 24 hours after death.

To the Funeral Director; Af investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BH 4 Borlin 9733 Health way mive 14 eechan 31. Date filed (Month, Day, Year) 32, Registrar's Signature State JAN 2 9 2009 Registrar

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Please Type or Print in Black Indebible Ink 1505 uge All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar #20b, #20c, TCHD, 01/15/2009. Certific 1. Decedent's Name (First, Middle, Last) Edward Leroy Anderson Certificate of Death TLS 2. Date of Death Month J Cun **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b(City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Eastor Talbot If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 07-05-1935 Director 217-30-9621 73 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at Anderson, Edward 12 Yes 2 □ No Director Md. Talbot r 28a-f Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 415 Salmon Ave. Funeral 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Maintence Driver and Mental Hygi Oriver Boatyard

18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Elroy Collins ပ္ Ellen Anderson Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is Department of Health Important: If Item 27 any Injury or other troops Elva Anderson / wife 600 Dutchmans Lane, Easton, Md. 21601 20a. Method of Disposition

1 → Burial 2 → Cremation 3 → Removal from State 20c. Location - City or Town, State Direct Crematory, LLC 01/16/2009 Richards Mem.Cem. 01-15-09 Dover, DE 4 Donation 5 Other (Specify) Easton, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Signature of Funeral Service License Easton, Md. 21601 426 Dover St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death and op Imonay Immediate Cause (Final **Physician** UNKhown disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, certificate has been sign rector, page 2 should be Caranona 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 ynwood AV LUSSELL ASCHILLING Easton md 21601 32. Registrar's Signature 31. Date filed (Month, Day, Year) **JAN 12** 2009 State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

Stephen P. Cafferty, DO

Year)

31. Date filed (Month, Day,

JAN 27 2009

32. Registrar's Signature

225 Town Square Drive Lusby,

			per fd pt 1/23/09 dly	se Type or Prin						•		9		
			1 - For State Registrar	State of Ma	ryland	-	tificate of				Reg. No	2003	04036	5
	Physicia /Medic		1. Decedent's Name (First, Middle,	Last)	I.		Buc	HMA		2. Date of De Month	eath Da		3. Time of Death 1744 M	1
4	Examin	er	4a. Facility Name (If not institution, give street and number) $130~{ t Hearn}~{ t Rd.}~~ \#1302$				4b. City, Town, or Location of Death Annapolis				4c. County of Death  Anne Arundel			
	Funeral Director		5. SogiogSogeum/Bumbog178 -209-18-2437	6. Sex 7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Min.	B. Date of Bir (Month, Da 9/19/1	av. Year)	9. B	irthplace (State or Foreign Country) IL	n
	aryland show	ž	Usual Residence of Decedent  10a. State  10b. County		10c. City, To								10d. Inside City Limits	
	h the M or 28a-f	Funeral Director	MD Anne A	Arunde1	Ar	napo	lis 10f. Zip Code				10g. Ci	tizen of What (	1 □ Yes 2 ☑ No	_
	ath wit	ral	130 Hearn Rd. #:	1302				21401	1			USA		
	ier des Items	nue	11. Marital Status	ver in U.S.	.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - An Black, Wh	nerican Indian, ite, etc.		
036	urs aff al", or Exal.	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 □Yes 2 ☑ No If Yes, Give Year or Dates:	U	1	□Yes 2√2No	Specify:				Specify:	White	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination at the million at once.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. K	and of Busines	s/Industry			
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<u>چ</u>	and		Daniel H. Smith	Son			aryland			vater,			<u>-</u>	
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altir	permit. P Departme Importan any Injur once.		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service)		1		Name and Addr					ntwood		-
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Division of Vital Records, P.O. Box 68760	spital or Attend nours after death neral Director: , filled in by the f	Certification: To								Street an vn, State	et and Number or Rural Route Number, State)		Ī	
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	300		39. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE H. 6, HWAY ANAPPOCIS MD 21401											
	Stat Registra	e ir	31. Date filed (Month, Day, Year)  JAN 2 3 2009  32/Registrar's Signature											

Boyce, Marylee

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	V. T.		1. Decedent's Name	(First, Middle, L	.ast)				2. Date of Deat	h	3. Time of Death
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	Examin		. A A	not institution, g	ive street and number)	10 1.	4b. City, Town, o	or Location of Death		C. County of Dea	th
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			Usual Residence of D	Decedent					37-10-	1924 Ma.	Lyland
	arylan show d at	_		10b. County		10c. City, Town					10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ttal Hyglene. 4d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	Md .  10e. Street and Num	Carol	ine	Ridge	-	-	1 4/	0	1 ☐ Yes 2 ☐ No
	with i		802 st:		ry Ct.		10f. Zip Code	2	"	0g. Citizen of What Co	ountry?
	ns 23	Funeral	11. Marital Status	rawber	12. Was Decedent	Ever in U.S.	21660 13. Was Decedent of H If Yes, specify Cub		ify Yes or No-	USA 14. Race - Ame	erican Indian,
<b>Q 9</b>	after o		1 □ Never Marrie		Armed Forces? 1 ☐ Yes 2 🕱 If Yes, Give	No	If Yes, specify Cub  1 ☐ Yes 2 🕱 No	an, Mexican, Puèrto R  Specify:	ican, etc.)	Black, Whit	e, etc.
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Z 2	illed Hygi other	Be	17. Father's Name (F	First, Middle, Las	st)			18. Mother's Name (	First, Middle, N	Maiden Surname)	
Vlan	ould be i Mental arked or	To B	u	ınk				Elizab	eth C	arr	
Maryland	es 1 and 2 should be filed of Health and Mental Hygis f Item 27 Is marked other r other traumatic event, ti	ľ	19a. Informant's Nan	-		.	Mailing Address (Street	and Number or Rural	Route Number,	City or Town, State,	
つうして re, Man	5€7 <u>;</u>		Dythin		ham/daugl		0.0.Box 92				
7) 8	iges 1 If ite or ot	- 3	20a. Method of Dispo 1 Burial 2 □		☐Removal from State	cemeter	Disposition (Name of y, crematory or other pla	i i		20c. Location - City or	
$\mathcal{D}_{\ell}$ Baltimore,	it. Pa irtmer irtant: njury		4 ☐ Donation 5			Croke	ers Cem.	01-2		Greensbo	ro,Md.
Ba	permit. Pag Department Important: Is any injury o		Signature of Full	Jerra Servade Lici	and the		426 DOX	er Street	nnie S	mith Fund	eral Home
	-		23a. Part1. Enter the	e disease, or co	mplications that caused	the death. Do n	ot enter the mode of dyin	er Street			Approximate Interval Between
	Physician	8 7	Immediate Cause (F	inal	y one cause on each lir	ne. Wancy	with 1	Luknow	· Pr	unan-	Onset and Death
	/Medical		disease or condition resulting in death)	-		a consequence o	f):	VICION	/C 111	Maria	10 days
ė	Examiner	I, I	Sequentially list cond	ditions.	ь	V				U	V
	sit ad	iner	Sequentially list conditions, leading to infinitional cause. Enter Underly Cause (Disease or in	mediate ying	Due to (of as	a consequence o	n):			•	
	be executed ician and burial-transit	Examin	that initiated events resulting in death) La		c Due to (or as	a consequence o	f):				
760,		=			`		•				
89	tificate g phy as the	Physician/Medica			U						
ŏ	th cerr endin	July N	IF FEMALE: 23b. Was decedent p		23c. If yes, outcome	pf pregnancy 2 □ Fetal death	3 ☐Ectopic pregnanc			23d. Date of del	ivery
B	deat he atte	sicie	in the past 12 m 1 ☐ Yes 2 ☐		4□Pregnant at 9□Unknown		5 Other (specify)	у		Month	Day Year
Ρ.Ο	nat the ded by the etached	Phy	9 ☐ Unknown	nont conditions		ut ant spoulting in	the underlying cause giv	na is Dad I	00- Did t-b		
ds,	The law requires that the death certificate the has been signed by the attending physbage 2 should be detached for use as the	by	Part II. Other signific	cant conditions	contributing to death bi	ut not resulting in	the underlying cause giv	en in Fart i.		acco use contribute to s 2 □ No 3 □ Pr	
Ö	v requ	etec									
Re.	sician: The law certificate has trirector, page 2 s	Completed	-						24a. Was an autopsy perform	y prior to	topsy findings available completion of cause of
ta			25. Was case referre	ed to medical				26. Place of Death		No 1 □Yes	2□ No
:	yslclan: is certific director,	To Be	examiner? 1 ☐ Yes 2 N	lo	Hospital:	ent 2 ER/Out	patient 3 DOA Oth	er.		nce 6 ☐Other (Spe	cify)
Ō	ding Phys n. After this funeral di		27. Manner of Death	5 ☐ Pending	28a. Date of Inju		ime of 28c. Injury Wor			w injury occurred	
Sio	tendli eath. or: A	Satic	2 Accident	investigation	he l	-4-50	M 1 🗆	Yes 2 □ No			
Division or Vital Records, P.O. Box 687	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determine		ury - At home, fan c. <i>(Specify)</i>	m, street, factory, office	28	f. Location (Str City or Town	eet and Number or Ru , State)	ıral Route Number,
	spital ours a leral I		29a. Certifier 1	Certifying F	Physician: To the hest	of my knowledge	death occurred at the ti	me date and place ar	nd due to the ca	usea(e) and manner as	stated
	24 h	edical	(Check only 2	☐ Medical Example	aminer: On the basis of	f examination and	l/or investigation, in my o	opinion, death occurred	d at the time, da	ate and place, and due	to the cause(s)
	W - W - 1		OHE)								
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	Me	29b. Signature and ti	itle of certifier			29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
	To the within To the compl	Me	29b. Signature and tr	itle of certifier			29c. Licens	5 3 8 / 5	29	ed. Date signed (Mont	h, Day, Year)
•	To the within To the compl	Me	29b. Signature and ti	itle of certifier	completed cause of de	eath (Item 23a) (1	29c. Licens D 00	5 38/5	29	od. Date signed (Mont	h, Day, Year)
~ ·	To the within to the To the Completion Stee	2	29b. Signature and ti	ss of person who	completed cause of de	eath (Item 23a) (1	29c. Licens D 0 0  Type, Print)  MARKET	53815 537, DE	EN 701	ad. Date signed (Mont	h, Day, Year)  V 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 Journ /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Deatl **Examiner** B 6 len macWoshineten Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2 1 ₹ F Months Days Hours 578-52-4372 Washington DC Director 3/17/1939 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 10a, State 10b. County 1 □Yes XXNo Director Anne Arundel Odenton MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21113 2290 Autumn Court Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Senate Legislative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Griffin Mary Wingate Frank ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; if Item 27 is any injury or other trauonce. 2290 Autumn Court Odenton, MD 21113 Son Eric Baugher 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/23/09 Glen Burnie,MD Atlantic Crematory 21. Signature of Funeral Service Lie 22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis 2Road Cambrills, MD 21054 Date Approximate Interval Between Oriset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of) Due to (of Examiner Sequentially list conditions, if any, leaving to minimalists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Live birth 2 Fetal death 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the irector, page 2 s autopsy performed 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2 No After this certure. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

I Director; Af d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b

P.O. Box 68760. Division of Vital Records,

State

Medical

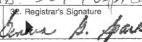
ARIA 31. Date filed (Month, Day, Year) JAN 23 2009 Registrar

29b. Signature and title of certifie

Name and address of person who cor

GAVIR

29a. Certifier



pleted cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 25 2009 ar 10:00AM MARY W. COLLINGWOOD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT EASTON WILLIAM HILL MANOR 8. Date of Birth (Month, Day, Year)
NOV. 27, 1927 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2¶ F WASHINGTON D.C. 81 184-24-1088 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f shove event, the Medical Eraminer must be notified at 1 Yes 2 □ No Director EASTON TALBOT MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 501 DUTCHMANS LANE 21601 e filed within 72 hours after death tall Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: WHITE ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COUNTY LIBRARY LIBRARIAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Mental is marked MARJORIE HAMILL EDWARD PINKNEY WROTH ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health item 27 i 5 CUMBERLAND COURT, ANNAPOLIS, MD 21401 MARJORIE C. KIMBLE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1; 20a. Method of Disposition Department of Important: If it any Injury or o ₽ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 1/26/2009 STEVENSVILLE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERA 200 S. HARRISON ST EASTON, MD 21601 HELFENBEIN & NEWNAM FUNERAL HOME PA JOHN MERCE ROF Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2011/0100 Secondo disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☑ No 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

 1 ☐ Yes
 2 ☐ No 24a, Was an cate has page 2 s autopsy certificate 2 🗷 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

σ. Division of Vital Records. ours after death neral Director: / filled in by the fi within 24 hours a

To the Funeral C

completely filled

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE EASTON, MD 21601 31. Date filed (N

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Im

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Florine Currie State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar I. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 2, 2009 1400 hrs Medical Examiner FLORINE H. CURRIE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre De Grace Harford 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** 7. Age (In vrs. last birthday) Foreign PENNSYLVANIA Country) Months Davs Hours Min Director 217-54-7836 04/07/1945 M 2X F 63 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MARYLAND HARFORD ABERDEEN with the Maryland Director 10e, Street and Number 10g Citizen of What Country 28 E. BEL AIR AVENUE, BLDG 40, APT 3 21001 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black death v 1 Never Married 2 X Married Armed Forces White, etc. Yes -Yes, Give Yea hours after Divorced Yes 2 X No specify: Specify: BLACK narked other than "natural", event, the Medical Examiner 6 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) it. Pages I and 2 should be filed within 72 I transition of Health and Mental Hygiene retant: If item 27 is marked other than ", y or other traumatic event, the Medical F. MD 21215-0036 PRIVATE SCHOOL 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) FLOYD PHILLIP YARBRAY SAMANTHIA ABRA MAE JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 VINCENT T. CURRIE / HUSBAND 28 E. BEL AIR AVENUE, BLDG 40, APT 3, ABERDEEN, MD 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State JAMES UNITED CEM. 2/24/09 HAVRE DE GRACE, MD Other Specify: Donation 5 21. Signature of Funeral Service Licenses 22. Name and Address of Faci LISA SCOTT FUNERAL HOME, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 21078 Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Peritonitis Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Dehiscence of surgical site Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed Physician/Medical PI line a-b, PII, 27, perME, g888 2/25/09 TT X UNPENDED ending physician use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 V No 9 Unknown g the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed 2 should be deta ģ Yes 2 No 3 Probably 4 ✔ Unknown hypertensive cardiovascular disease, diabetes Completed Records. 24a Was an 24b. Were autopsy findings available mellitus, cirrhosis of the liver, chronic alcohol autopsy prior to completion of cause of certificate has performed? page ✓ Yes 2 1 🗸 Yes 2 No use Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) director, Division of Vital Be examiner? Hospital: Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 After this 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Yes 2 Pending 24 hours after death. Funeral Director: the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number. City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 3, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** Mary Yolanda Compofelice 11:50 p 26, 2009 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery General Hospital Olney
If Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 🔀 F 578-20-0813 4, New York 1922 86 Aug. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20832 18918 Cloverhill Lane USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: ð 3X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Joseph Giacalone Laura Ventimiglia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health 12101 Baugher Drive, Thurmont, MD 21788
of Disposition (Name of Date 20c. Location - City or To Joseph M. Compofelice/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot Jan. 30 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 anc Approximate Interval Between Onset and Death 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Obstructive **Physician** 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 2 🗐 No certificate has been signed by the rector, page 2 should be detached 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 1 □ Yes 1 ☐ Yes 2 🗆 Ko funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier (10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prive Philip DR

DHMH 17 Rev 1/2001

State

Registrar

DCH DENGULD

31. Date filed (Month, Day, Year)

JAN 28

40 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Maryland Tepariment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2-4-2009 Helen Ann Coolbaugh 4a. Facility Name (If not institution, give straet and number) 4c. County of Death 4b. City, Town, or Location of Death Kline Hospice House Frederick Mt. Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1–18–1925 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🛛 F PA 84 184-12-1025 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No New Market Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21774 10678 Finn Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 No Specify: 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Ma. Helen Grabowski 17. Father's Name (First, Middle, Last) Joseph Snarski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3010 Roderick Road Frederick, Maryland 21704 Robin Stone Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 2-9-2009 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Euneral Service License M01176 106 East Church Street Frederick, MD 21701 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 moorns?
1 Ves 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 26. Place of Death (Check only one) Hospica

**Physician** /Medical **Examiner** law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

Director

Funeral

2

Completed

Be

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d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be multilled.

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur

Baltimore, Maryland 21215-0036

sician and burial-transit attending physician for use as the buria ed by the certificate has been signed by irector, page 2 should be detact To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division of Vital Records, P.O. Box 68760,

Physician/Medical Completed Be Certification: To

Examine

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

27. Manner of Death Natural 5 Pending investigation 2 Accident 6 ☐ Could not be

3 Suicide 4 ☐ Homicide

(Check only one)

29a. Certifier

🕊 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated 29b. Signature and title of certifie

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work?

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

501

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

Registrar's Signature 32.

Es Kander

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Anna G. Dawson 18 0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** COASTAL HOSPICEATTHE SALISBUR WICOMI 00 8. Date of Birth (Month, Day, Year 9/12/1922 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 1 □ F 86 Director 201-12-5835 Usual Residence of Decedent the Maryland 10a. State 10b County 10c City Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examine must be no once. 3 Ash COurt 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify white Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John J. McCloskey Anna Corbett ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 Beaconhill Rd., Ocean Pines, MD 21811 Jane Mooney / niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of Grace Cem 1/31/09 Langhorne, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home Funeral Service 108 William St., Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician BOSTAGIZ CARDIOMY OPA TI+ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGRISTIUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached q Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 2/1/10 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes A□No 24a. Was an autopsy performed? Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → ¥6 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 2. To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1005 8410

BA 15

ANN

SOUSE

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 9 21

COASTON 'HOSPI
32, Registrar's Signature
Server B. Space

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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H	State Registra	
DHN	/IH 17 Rev 1/20	01

			Please Type or Print ir State of Maryl		delible Ink. Ensure . artment of Health and			
			1 - State Registrar		tificate of Death		eg. No. 2000	n link
	Physici /Medic		1.Decedent's Name <i>(First, Middle, Last)</i> Ruth Elizabeth Dean			2. Date of Dear Month January	Day Year	3. Time of Death 3:45 A M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Death	
			Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Age (In )	vrs. last birthday)	Annapolis If Under 1 Year   If Under 24 Hr	S.   8 Date of Right	Anne Arı	indel  place (State or Foreign
	Funeral Director		220-32-7263 1 M 2M F 84	Yrs.	Months Days Hours Mir		Year) Coo 1924 Mar	yland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Marcal Examination, ust be maiffed at once.	lor	10a. State 10b. County 10c.	City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the P	by Funeral Director	Maryland Anne Arundel  10e. Street and Number	Loth	10f. Zip Code	1	0g. Citizen of What Cou	intry?
	h with	a D	325 Boones Drive		20711		USA	
	deat	ıner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Was Decedent of Hispanic Origin? ( f Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer Black, White	
36	or it	γF	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1	I □Yes 2 No Specify:	rto riiodii, oto.,		
21215-0036	hours ural"	d be	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10a David				White
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	at Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, I		
<u>lar</u>	ould be fi Mental H larked ot latic evel	70 E	unknown			unkn	iown	
Maryland	2 sho and l	1	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or F			
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Baltimore,	ges 1 If of F If ite or ot		I Buriai 2 kg Cremation 3 Li Removal from State		sition (Name of natory or other place)		20c. Location - City or T	own, State
Ħ	it. Pa rtmer rtant: njury			Kalas Cr		27/09	Edgewater	, MD
Ba	permi Depar Impor any ir		21. Signatur et Funeral Service Idensee		Name and Address of Facility G 973 Solomons Isl			
4.	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the candidate cause (Final disease or condition resulting in death)  23a. Part1. Enter the disease, or complications that caused the candidate cause (Final disease or condition resulting in death)	ion Pro	er the mode of dying, such as cardi	ac or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Examiner	j.	MILLERAR	DIAL	Infarction			24 Lrs.
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	sequence or).	,			
760,	e be executed sician and burial-transit	a l	resulting in death) Last Due to (or as a con	sequence of):				
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O. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of prediction in the year 1 □ Live birth 2 □ If 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
ď.	w requires that the de been signed by the should be detached i	y Ph	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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ioi	endlr sath. or: Al	atic	2 Accident investigation	,,	M 1 ☐Yes 2 ☐No			
Division	al or Att s after de l Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, streecify)	eet, factory, office	28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, death nination and/or in	n occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the courred at the time, c	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	\U	29c. License number	_	29d. Date signed (Month	
	and	N	30. Name and address of person who completed cause of death	Itam 22a) /Time	Drint)		01-22-2	001
	SID				ical Pkwy., Anna	nolie MD	21/101	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's S	gnature		POTTO III	4140I	
	Regist	ar	JAN 2 3 2009 Breus	A. Sa	aked			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Las, 2. Date of Death Day Year Physician 2009 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner dansto 9. Birthplace Country) (State or Foreign . Age (In yrs. last birthday, If Under 1 Year | If Under 24 H Date of Birth (Month, Day, Social Security Number **Funeral** 8 Min. Year. Months Days Hours Director Pennsylvania Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Frederick MD 1X Yes 2 No Director Adamstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3200 Bakers Circle, #25 21710 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 If Yes, Give 1 ☑ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify Specify: White ģ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Poultry Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Nist Joseph Charles Derda P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. 6505 River Road Bethesda, MD 20817 Susan Utley-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Alleghany Co.Mem.Park 01/31/2009 Allison Park, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike 21. Signature of Funeral Service Licenses Rocville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the 9 Unknown 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 2 10kg 1 ☐ Yes 2 ☐ No 1 ∐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 1∐ Yes 2 **2** No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 TResidence 6 Other (Specify) this 28a. Date of Injury (Month, Day, Year) funeral Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 🖍 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

completely

Medical

(Check only one)

30. Name and address

29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

ompleted sause of death (Item 23a)

Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Douglas Foster Estelow

2009 04047

		I- For State Registrar				Certific	ate of l	Death	7			Re	g. No.			
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		4a. Facility Name (if not instit					4b	. City, To	own, or Lo	ocation of		201		ty of Death	* _ 4 7 7	
		Rt. 50 East bound /						Easto	n			T.	Talbot			
Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last bir	thday) · ·	If Unde Months	_	If Under Hours	Min			Co	thplace (State or Foreign untry)	
Director		154-72-1629	1 X M	2F		30	Yrs.	Worth	Days	110010		OCTOBE	R 3,19	78 NE	W JERSEY	
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death	Funeral	1 Never Married 2 X	Married	Armed Fo	rces?	No					Puerto Ri	can, etc.)		7.77	HITE	
after	b F			Yes, Give Year Dates:					X No		and of word	di dana	Special Special	у.		
hours 'natur Exam		15. Decedent's Education ( Elementary/Secondary (0-		College (1		ted) 16a.	Decedent's during mos					etired)				
on 72	ompleted	Elementary/Secondary (o-	12)	College (1	-40131)	M	1ERCHA	NT				RETAIL OFFICE SUPPLIE				
5-0036 ed within 72 tygiene. other than	Con	17. Father's Name (First, Mic	dle, Last)						18	3.Mother's	Name (F	irst, Middle, M	Maiden Surna	me)		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be (	DONALD HOR	ACE ES	TELOW							ET L					
21 nould bed Mer is mar	은	19a. Informant's Name/Relat				19						ral Route Num				
MD ng 2 sho alth and m 27 is		COURTNEY EST: 20a. Method of Disposition	ELOW/W	IIFE		20h Place	1138 of Disposit					, CENT			) 21617 r Town, State	
Baltimore, MD 21215-003 pernit, Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		1 Burial 2 X Crema	tion 3	Removal fro	om State		PEART	er per			FEB.	7		,		
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1760, ficate be ex g physician the burial	Nedi	IF FEMALE:		23c. If yes,	outcome o	of pregnanc	V						23d. Dat	e of delive	ry	
3876 rtifica ling ph		23b. Was decedent pregnant past 12 months?	in the	1 Live b	irth		-	al death	3	Ectopic	pregnan	су	Mont	h	Day Year	
Sion of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certific death ector: After this certificate has been signed by the attending I by the funeral director, page 2 should be detached for use as it	Physicia	1 Yes 2 No 9	Unknown	4 Pregr		e of death	5 Oth	er (Spe	cify)							
that the denet by the detached if	Phy	Part II. Other significant co	nditions o	contributing to		ıt not resulti	ing in the ur	nderlying	g cause gi	ven in Pa	rt I.	23e. Did to	obacco use c	ontribute to	o the cause of death?	
<b>P.O.</b> ires that the signed by the detached	l by							_				1Ye	s 2 🗸 No	3 Pro	obably 4 Unknown	
of Vital Records, ng Physician: The law require ther this certificate has been s' meral director, page 2 should b	ompleted											24a. Was		b. Were a	autopsy findings available completion of cause of	
Recol The law cate has	ld m												rmed?	death?		
tal Rectian: The certificate ector, page	e C	25. Was case referred to me	dical	_					26.Place	of Death	(Check or	nly one)				
Vital F hysician: this certifi al director,	o Bé	examiner? 1 ✓ Yes 2 No	Но	spital: 1	Inpatient	2 ER/	Outpatient	3	OOA	Other <sub>4</sub>	Nursing	Home 5	Residence	6 🗸 Oth	er: Scene	
n of V ling Phy After th	-	27. Manner of Death		28a. Date	of Injury Day Year	28t	. Time of In	ijury	28c. Injur	y at Work		28d. Describe Driver auto				
ion Itendia leath tor: /	atio		Pending Investigation	, l			23 hrs			es 2 🗸	No					
	Certification:	3 Suicide 6	Could not be	28e. Plac		- At home,		t, factory	, office bu	uilding, et	c. 2	28f. Location ( or Town,	Street and No State)	umber or F	Rural Route Number, City 55, Easton, MD	
Spital hours neral fillec	Cer	4 Homicide	determined			Road / I	<u> </u>									
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only one) 2 Medical	nowledge, d ation and/o	ieath occurr r investigati	red at the on, in m	e time, da y opinion,	te and pla death oc	curred at	tue to the cau the time, date	and place, a	nd due to	the cause(s)				
To To Com	Med	29b. Signature and title of co		and manner s	stated.				c. License						onth, Day, Year)	
		ante							O.C.N	И.E.			Februar	y 5, 200	9	
_		30. Name and address of pe	rson who co	mpleted cau	se of deal	th (Item 23a	1)									
1				Medical	Examin	er 111	Penn S	treet, l	Baltimo	re, MD	21201					
S	tate	31. Date filed (Month, Day, Y	ear) Q 2		edistrar's	Signature	1 1	2 Klas	1							

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				State of Marylar	nd / Depa		lealth and M	ental Hygi		09	04048
				Registrar  1. Decedent's Name (First, Middle, Last)		timodito or		2. Date of Death			3. Time of Death
		Physici		Dorothy Irene Marsh Fli	nt			1/21/	Day 2009	Year	6:57A M
5		/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	1/21/	4c. County	of Death	_ <del></del>
D: 045		Examil	ei	Homewood at Crumland Farm	ıs	Fred	erick		Fre	deri	.ck
$\mathcal{O}$		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birth	Yoarl -	9. Birth	place (State or Foreign ntry) SSOURI
		Director		267-28-5285   ¹□M <b>¾</b> □F   88	Yrs.	Months Days	Hours Min.	8779	1920	Mis	Souri
Ċ		P .		Usuel Residence of Decedent	ty, Town or Lo	1					10d. Inside City Limits
		ehow	<u>.</u>	MD 10b. County 10c. Ci	-	rederic	l-				1 Yes 2 XNo
-		the Market Processing	cto					4.0	0000000000	4/5-4-0	
		uth with the Maryla 23a or 28a-f ehov	声	10e. Street and Number 7407 Willow Rd •		10f. Zip Code	21702	10	g. Citizen of	US	-
0		s 234	- E		10 10			offy Ves or No.	14 Rac		can Indian,
O		ltem Trem	Ë	Armed Forces?	7.3.	f Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		ck, White,	
_	36	irs af	by f	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 27 No	Specify:		Specif	Whi	.te
1/21/00	5-0036	within 72 hours after death with the Maryland one. than "naturel", or Items 23e or 28e-f ehow the Medical Examinar mast be notified at	ted	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of B	usiness/lr	ndustry
_	215	hin 7	pie	(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1·4or 5+)	life.	DO NOT use retired	ation during most of worki d)	ng			
1	2121	giene Thu	Ö	5+	t	eacher				hool	S
01	p	al Hygid I other	To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Sumar	ne)	
$\dot{\circ}$	Va	should be find Mental Find Mental Find Mental Find Mental Find Mental Find Find Find Find Find Find Find Find	၉	William Virgil Hollopeter			Ruth Ma				
0.00	Maryland	d 2 should h and Mer 7 le marke traumatic		19a. Informant's Name/Relationship (Type, Print) Gregory Marsh (Son)	19b. Mailir	ng Address (Street	and Number or Rura	Poute Number, Mid	City or Town,	, State, Zi, Turn .	MD 21769
(		l and leelth im 27 her ti							0c. Location		
	Baltimore,	iges 1 if of P if ite		1 Burial 2 Cremation 3 Removal from State	cemetery, crei	natory or other place	ce)	41.		-	
4	ţ	t. Pa rtmen rtant:		4 Donation 5 Other (Specify) SI		_	matory1,				
FINE	Bal	permit. P Depertme Importan any injur	,	21. Signature of principal Service 11589	É	onald E	Sof Thomps Middleto	son Fun own, MD	eral 2176	Home 9	2
				23a. Part 1. Enter the disease or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory arre	st,		Approximate Interval Between
		Physician		Immediate Serse (Final disease or condition	DRATI	40.					Onset and Death
5		/Medical		resulting in death)  Due to (or as a consec							11 -000
ナ		Examiner		Sequentially list conditions b. DEMEN							10 YEARS
といういっく		ם ב	Examiner	Sequentially list conditions, if any, leaving to liminediate cause. Enter Underlying Cause (Disease or injury that initiated events	querina of):					- 1	
00		ecute and trans	me:	Cause (Disease or injury that initiated events c. resulting in death) Last Due to for as a consei							
2	760,	be executed sicien and burial-transit		Due to (or as a consec	querice (ii).						
	87	sate b	dical	d						-	
3	89 x	leath certificate t attending physical for use as the b	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregn	ancy				aa i D		
0	Вох	attend attend for us	lan	in the past 12 months?	al death 3	Ectopic pregnancy Other (specify)	/			ate of deliv onth	Day Year
S	P.O.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	J94(I) 3[	Other (specify)					
9		that the d ed by the detached	문	Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use con	tribute to	the cause of death?
Physicians	Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	d by	PARKINSON'S DISEASE		, , ,		1 🗌 Ye:	2 <b>2</b> No	3 🗌 Pro	bably 4 Unknown
2	Š	w require been si should b	ete	SCHIZO- AFFECTIVE DISOR	DEL			24a. Was an	24h	Were aut	onsy findings available
3	Rec	has ge 2	ompieted	2CHIECT III FEST				autopsy perform	ed?/	death?	opsy findings available ompletion of cause of
=	<u>=</u>	ician: Th certificate rector, pag	O					1 ☐ Yes 2		1 🗌 Yes	2 No
ā	Ϋ́	ysician: The l is certificate ha director, page	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐	1.CD/O	Ott	26. Place of Death	me 5 ☐ Resider		has (Casa	4.3
	to.	Phys rthis raldi	5.7	27. Manner et Death  1/DVatural 5 Pending (Month, Day Year)	28b. Time o			28d. Describe hor		<del></del>	ny)
1	on	ding Ph th. After th funeral	ţ	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		rk?  Yes 2 □ No				
	Division	or Attendi after death. Director: A in by the fu	ertification:	3 Suicide 6 Could not be	nome, farm, st	reet, factory, office				ber or Rui	al Route Number,
3	Δi	after after Direct	ert	4 Homicide determined building, etc. (Special	ify)			City or Town,	State)		
Known		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Physicien: To the best of my kn	owledge, deat ation and/or in	h occurred at the tile tile tile tile tile tile tile til	me, date and place, ppinion, death occurr	and due to the ca	use(s) and m te and place,	anner as and due	stated. to the cause(s)
Y		To the Ho within 24 To the Fu completely	Med	one) and manner stated.		29c. Licens			d. Date signe		
		CO TWIT	~	29b. Signature and title of centifier	Cus	Zac. Licens	20488	29	1 - 2 1		
		2	Ì	The state of the s							
	(			30, Name and address of person who completed cause of death (Ite	m 23a) (Type,	CHURCH	, ST, N	liddres	own,	MT	>. 21769
		Sta Regist	ate rar	31. Date filed (Month, Pay, Year) 32. Régistrar's Sign	ature,	and I					

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			For Amend Item State of Mary a State Registrar	8,12/22 Cei	109di rtificati	t of H e of L	ealth a	and M	lental Hy	/giene Reg. No.	2009	01	049
	Physicia		1. Pocedent's Name (First, Middle, Last). ANTOLNETTE FEVIUGLO						2. Date of D Month 02/0	eath 2/2 <sup>D</sup> 00	9 Year	3. Time 0643	of Death Á M
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital		4b. City, Hav.	Town, or re d	Location e Gro	of Death		4c. 0 Ha	County of Deat rford	h	
	Funeral Director		5. Social Security Number 6. Sex 1. 33 - 05 - 0625 1. M 2 ★ F 89	rs. last birthday) Yrs.	If Under Months	1 Year Days	ff Under Hours	24 Hrs. Min.	8. Date of B	irth Pay Year) 1919	9. Birt Co New	hplace (State	e or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation							10d. Inside	City Limits
	he Many 28a-f eh cuttlest	ector	Maryland Harford Ab	erdeen	104 7:-	C-1-				10a Citiz	en of What Co	- ' '	es 2 No
	th with t	Funeral Director	901 Barnett Lane		10f. Zip 210								America
(1) 1036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-1 ehow eny injury or other treumatic event, the Medical Examiner must be notified at once.	٥	11. Maritaf Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates:		Was Deced If Yes, spec 1  Yes		spanic Or n, Mexicai Specify:		ecify Yes or N Rican, etc.)		4. Race - Ame Bfack, Whit Specify: Wh		
643 (d 21215-0	within 72 h ene. then "natu he Medical	ompletec	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life. Home)	kind of wo	al Occupa rk done d se retired	ation <i>furing</i> mos )	st of work	ing		d of Business/ amily	Industry	
9 0643 and Maryland 21215-0036	uld be filed Mental Hygi irked other itic event, I	To Be Completed	17. Father's Name (First, Middle, Last) Angelo Amico						e (First, Middle Le Gior		Gu <i>m</i> ame)		
9 Many	nd 2 sho lith and I 27 ie ma r treuma		19a. Informant's Name/Relationship (Type, <i>Print)</i> Andrea Warner- Daughter	19b. Mailir 306	ng Address SNOW	Chie	od Numb	eror Aura	al Route Num. avre d	per, City or e Gra	Town, State, 2 Ce Mouri	ip Code) Jland	21078
	ages 1 au int of Hea t: If item y or othe		20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	p. Place of Dispo cemetery, crer View	osition (Nari matory or o Ceme	ne of ther place tery	9)		Date 5/2009		ation - City or etown,		ersey
2/2/0	permit. F Departme importan eny injur		21. Signature of Funeral Service They says	122	2. Name an 2.3 So	d Addres	s of Facili	ing to	lman F n Stre	et, H	e Home, ayre de	P.A. Grac	e, MD
			23a. Part1. Enter the disease or complications that caused the deshock, or heart failure list only one cause on each line.  Immediate Cause (Finaf disease or condition BILM?	eath. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory		078	Approxin Interval E Onset an	nate Between
	Pnysician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a cons		774	C 0 1	(0.0						
11248	ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a conscient of the	,									
100H 68760,	fficate be physicias the bu	edical	d						···				
2. H 800.	ires that the death certificat signed by the attending phy d be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1000 9 ☐ Unknown  23c. If yes, outcome of pregnant in the past 12 months? 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pr Other <i>(sp</i>					2	3d. Date of del Month	ivery Day	Year
rds, P	quires that n signed b uld be deta		Part II. Other significant conditions contributing to death but not a	resulting in the u	nderlying c	ause give	n in Part	l.			e contribute to		
ntoine	: The law requir cate hes been si , page 2 should	Completed							per	s an opsy formed? 2-2 No	death?	itopsy finding completion of	s available cause of
4 12	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospitaf: 1 1 ☐ Inpatient 2	. ☐ ER/Outpatier	nt 3 🗆 DC	Othe			n <i>(Check only</i> me 5 ☐ Res		☐Other (Spe	cifv)	
	ding After fune	atlon; T	27. Manner of Death  1. Natiural 5 Pending (Month, Day Year, 2 Accident investigation	28b. Time o		8c. Injury Work	at		28d. Describe			,,	
デスス Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spe	ecify)			M.C.		City or T	own, State)	Number or Ru		umber,
Te	the Hospital nin 24 hours of the Funeral I npletely filled	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my king on the basis of examiner and manner stated.	knowledge, deat ination and/or in	h occurred vestigation	at the tim , in my op	ne, date ar pinion, dea	nd place, ath occuri	and due to the red at the time	e cause(s) a , date and	and manner as place, and due	stated. to the cause	∍(s)
	To the To the Comp	M	29b. Signature and title of certifier  Adwidownline	2: MI			number 80	96			signed (Mont		
			30. Name and address of person who completed cause of death (f  ANDREW NOW ACCESSES	item 23a) (Type,	Print)	7	FUL	For	RP 1	7/2	BEZAN	P.MD	21014
ı	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Sig	gnature	barke	g		101			- //	1/ 1-	

DHMH 17 Rev 1/2001

State Registra amend #26PerPhysCCHD 1/28/09 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 9:03 PM JANUARY Gaines Lucille Agnes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES CIVISTA MEDICAL LAPLATA CENTER 8. Date of Birth (Month, Day, Year)
May 21,1928
Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number Sex 14 M 2 F 7. Age (In yrs. last birthday) **Funeral** Days Months 80 Director 213-24-3833 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show aţ 1 X Yes 2 □ No Director Charles Nanjemoy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò pe 4200 Gaines Place 20662 II S A 23a the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 10. 1 ☐ Yes 2 No Specify: Specify: ģ 3 X Widowed 4 ☐ Divorced Black "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If frem 27 Is marked other the any Injury or other trainment. 6 0 Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie Richardson Daniel Lawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20662 1790 Port Tobacco Rd., Nanjemoy, Md Washington/Daughter Laveren Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 1/24/09 |Nanjemoy, Md. 4 Donation 5 Dother (Specify) Oak Grove Cemetry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bluford Funeral Service fle K 2019 Martin Luther King Ave., Wash. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Merone disease or condition resulting in death) /Medical Due to (or \*s a consequence of): Examiner W Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as/a consequence of Examiner certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical as the I attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 - NO 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 ပ 1 🔲 Inpatient 2 XER/Outpatient 3□ DOA this in by the funeral 28a. Date of Injury 28b. Time of after death. 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Hospital or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one).-29b. Signature and title of dertifiel 29d. Date signed (Morth, Day, Year) 29c. License number d 225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT PACE, MD. 12070 OLD LINE CENTER SUITE 302. WALDORF MD 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25 2009 Year O Month **Physician** 3:04 A M Houston Gregory Harvey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Hurlock 117 Goldrush Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours 1**X** M 2□ F 01-04-1938 ۷a٬ 71 Director 223-44-7410 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Md. Dorchester Hurlock 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21643 117 Goldrush Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Leyes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itel any Injury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify. Specify: ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Allens USDA Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Anderson Francise မ Jerome Nathaniel Gregory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
117 Goldrush Lane, Hurlock, Md. 21643 19a. Informant's Name/Relationship (Type. Print) Betty Gregory / Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Veterans Cem. 02-02-09 Hurlock, Maryland Md. Signature of Fun all Sarvice Licenses Bennie Smith Funeral Home Main St., Hurlock, Md. 21643 516 S. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician MOD. /Medical Tue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit JUNUN Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy 1□ Yes 2 Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Wedical completely (Check only within 24 and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

VA+3 State 30. Name an

31. Date filed (Month, Day, Year)

JAN 28 2009

115

DHMH 17 Rev 1/2001

Registrar

302 Collins Hurlock Md 2/643

erson who completed cause of death (Item 23a) (Type, Print)

w 32. Registrar's Signature

Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 23, 20**0**9 3:36 A M Michael Jorge Curzo Guevara 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 17 1987 21 Mar Peru n/a Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 □Yes 2X No MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 Peru 11633 Lockwood Drive #T3 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 XYes 2 □ No Specify. Hispanic Specify. Peruvian 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Painting Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gaby Guevara Jorge Curzo Ramirez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11633 Lockwood Drive #T3 Silver Spring, MD 20904 Gaby Budd/mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 01/27/09 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral service bic Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Cardiopulmonary Arrest Due to (or as a consequence of) b Respiratory Failure Bilateral Pneumonia Due to (or as a consequence of) Small Bowel Obstruction 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner executed Division of Vital Records, P.O. Box 68760,

burial-trar attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be certificate has be irector, page 2 sl After n 24 hours after death. Re Funeral Director: Appletely filled in by the fu To the within 2 To the Complet

Physician

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d other than "natural", or items 23a or 28a-f shovevent, the Medical Examination and the notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'any injury or other traumatic event, If a Mee.

Physician

/Medical

1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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Sequentially list conditions, if any, resume a himselate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Resistant Burkitt's Lymphoma Completed Failure to Thrive Pancytopenia 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

31. Date filed (Month, Day, Year) JAN29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



M.D

State

Registrar

D68100

January 23, 2009

			1 - For State Registrar	State of	Marylan	•	artmen					jiene	009	04053
E	Physici		1. Decedent's Name (First, Middle								Date of Dea Month	Day	Year	3. Time of Death 2:50 P M
	/Medic Examin		4a. Facility Name (If not institution		ber)			Town, or	Location of		January	4c. Cou	nty of Death	
	Funeral Director		St. Vincent 5. Social Security Number 220-56-2228		er 7. Age (In yrs. 97	last birthday) Yrs.		1 Year Days		Min.	Date of Birth (Month, Day pril 10	Year)	9. Birth	place (State or Foreign ntry) nada
	Maryland 8-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Frede	erick		y, Town or Lo								10d. Inside City Limits 1 √ Yes 2 □ No
	ath with the	ral Director	10e. Street and Number 355 South Se			-		2172				Og. Citizen	State	es
036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ta Marikeal Examitien must be codified at	by Funeral	11. Marital Status 1∰ Never Married 2☐ Marri 3☐ Widowed 4☐ Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? 2 Man P		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		fy Yes or No- can, etc.)	E	lace - Ameri Black, White, cify: Whit	etc.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or itame 23e or 28e-f show or other traumatic event. Else Waltes Examilise must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-	4or 5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	k done d	luring mos	t of working		_	ous C	ommunity le Namur
yland 2	should be filed nd Mental Hygi marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Francis	Last)	bee	1				er's Name ( lizab	First, Middle,		ame)	
e, Mar	1 and 2 sho Health and em 27 ie m		19a. Informant's Name/Relationsl Sister Camilla 20a. Method of Disposition	,	20b. P	333 S	S. Set	ton I	Ave./		Route Numbe tsburg		21727	
Baltimore,	t. Partmer		1 M Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)  21. Signature of Funeral Service	oecify)	itate C	emetery, crer sters c	natory or o	ther place cre D	ame		2009 ffer F	Ellico	ott Ci	
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	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	or as a conse	uence of):	ul b	en	u t f	Place	lul 2	~	1	[ Marth
8760,	cate be executed physiclen and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	r as a conseq or as a conseq	uence of): uence of):	Ĉ	rid	ieva	scul	a A	ulon	l	Kyeos
.O. Box 68	The law requires that the death certificate be executed to hes been signed by the ettending physicien and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pro					1	Date of delive	ery Day Year
٥.	w requires that been signed b should be deta	þ	Part II. Other significant condition	ons contributing to de	oth but not res	ulting in the u	nderlying ca	ause give	on in Part I.	,	23e. Did to	300		he cause of death?
Division of Vital Records,	: The law recete hes be page 2 shd	Completed				-					24a. Was a autop perfor	sy	prior to co death?	opsy findings available impletion of cause of 2 No
<u> </u>	eician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	patient 2	ER/Outpatier		Othe			Check only or		Nt (0	(1)
o (	g Phy ter this neral d	n: To	27. Manner of Death	28a. Date o		28b. Time of		8c. Injury Work			d. Describe h			ry)
ivisior	i or Attending Physician: efter death. Director: After this certifics I in by the funeral director, I	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	of Injury - At ho g, etc. (Specif	ome, farm, str	М	101	/es 2 □		f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	al Route Number,
۵	Hospita 4 hours Funerel tely filled	edical Cel	29a. Certifier 1 Certifyin (Check only 2 Madical	g P <b>hysician</b> : To the Examiner: On the ba and mann	sis of examina	wledge, death	n occurred vestigation,	at the tim	e, date an pinion, dea	d place, an	d due to the d	ause(s) and late and plac	manner as s	stated. o the cause(s)
ľ	rother complete	Me	29b. Signature and title of certifie	la Co	wal	l N	290	. License	number	05	à	29d. Date sig	ned (Month, 24 (	Day, Year)
(	4)		30. Name and address of person Alan Carrol		of death (Item	23a) (Type,	Print)							
	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	iture	,							4.800.000

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 9:35 January KELLY SUE GLOYD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 212-88-0801 Director Maryland AUG.27,1963 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, traff officer Examinat must be redfined at Maryland Frederiick Mount Airy Director 1 ☐ Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5805 Catoctin Overlook Dr. 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify: Specify: White ⋧ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, Its Medione. College (1-4or 5+) Elementary/Secondary (0-12) Administration Assistant 12 Mortgage Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Holler Barbara ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Gloyd / Husband 5805 Catoctin Overlook Dr./Mount Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem. 01/27/2009 Frederick, Maryland of Funeral Service Licen 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part 1. En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Juse (Final Breast cancer **Physician** neurs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): the attending physician the for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? effusions 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖬 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 The Hospital or Attending Physician: To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death.

and

has

certificate

After this

should be filed within 72 hours after death with the Marylanc

altimore, Maryland 21215-0036

show

completely

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier KIZVIMP

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West 7th Sheet, Frederick

400 West 7th Sheet, Frederick 32. Registrar's Signature 31. Date filed (Month,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last, Day **Physician** 10:50 AM 0 Mqustas 20 2089 aston /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Worcester Hospita f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2□ F 263-37-2019 80 **Director** Jamaica Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be nutified at 1 Yes 2 No Director MD WORC es 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1008: 7/20/40 D6D: 1720/09 Baltimore, Maryland 21215-0036 1 Never Married 2 Married Specify: Black "natural", or 1 ☐ Yes 2 No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) marked other than 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau Henru Berlin 12010 ND Date 20c. Location - City or Town, State Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) *tocomoke* 917 W. I Subella Street Salisbury Mp 21801 tureral Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MYDCAKDIA MIN-S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to involve cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner for use as the burial-transi and resulting in death) Last Due to (or as a consequence of): 37-2019 P.O. Box 68760, physician requires that the death certificate be Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 No 2 🗆 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1XYes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zemedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month)

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Warks

MORTH / Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Nancy Ann Ingersoll Hattenbach 1/21/2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1/27/1933 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2FXF 75 465-44-4732 OHIO Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 60 Millhaven CT. 21037 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W. Ingersoll Bernice Gair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Lee Reilly Daughter 60 Millhaven Ct. Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Atlantic Crematory 1/28/2009 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 | AK 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 053306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) estante Rd ste 300 Ampapolis 5 tarris MO 900B nth, bay, Year) JAN 27 31. Date filed (Month 32. Pegistrar's Signature 2009 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of rtificate of		Mental Hy	giene Reg. No. 2	nno	01.05
			Decedent's Name (First, Middle, Last	t)				2. Date of De	eath	Vee:	3. Time of Death
	Physici /Medio		Marylou Reed Huse					Januar	y 20, 2	009	11:35 A M
-	Examin		4a. Facility Name (If not institution, give				or Location of Dea	th	4c. County		
			Anne Arundel Medi			Annapol			1		undel
	Funeral		5. Social Security Number 6. S	DM OME	(In yrs. last birthday)	If Under 1 Year Months Days			th ay, Year) 1.037	Cour	place (State or Foreign
	Director		005-24-0345 Usual Residence of Decedent	\	B1 Yrs.	L		0/10/	1927	Com	nécticut
	ow s		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary Frsh	tor	Maryland Anne Ar	undel	Anna	polis					1 ∐ Yes 2 📉 No
	r 28g	irec	10e. Street and Number			10f. Zip Code	· · ·		10g. Citizen of	What Cour	ntry?
	th wit	Funeral Director	820 Coxswain Way			21401			USA		
	ens	nel	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🖾 No	ver in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	14. Ra	ce - Americ	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	0	1 □Yes 2【No			Specia	5.0	
8	hour tural	edt	15. Decedent's Ed	Year or Dates:	16a, Dece	dent's Usual Occu	nation		16b. Kind of B		hite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Widgol Evan, mar must be multified at	Completed	(Specify only highest gra	de completed)  College (1-4or 5+	(Give	kind of work done DO NOT use retire	e during most of wo ed)	orking			•
212	d with giene	mo;	Elementary/Secondary (0-12)	4 years		nemaker			Home		
pu	al Hy al Hy I othe vent,	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle		ne)	
yla	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, It. W. doal Evan.	으	Carlton	Day Reed			1	Louise			
Mar	2 sho and is ma		19a. Informant's Name/Relationship (7	Type. Print)			et and Number or F				Code)
6,	1 and 2 Health tem 27 i		Margaret H. Larso 20a. Method of Disposition	n/ Daughte			na Dr., H	ope Mill	.s, NC 2		wn State
סר	ages nt of l		1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, crei						
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, IT. M. once.		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Solving Licen		Kalas Cr		1 / Z ress of Facility G	2/09			Maryland
Ba	Deparement		VIIIIIIIIIII				omons Isl				
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do not en						Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	one cause on each line	Pheumo	ma					Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):						
	Examiner	_	Sequentially list conditions,	b				AAR-AA			
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):						
•	s be executed sician and burial-transit	xar	that initiated events resulting in death) Last	C Due to (or as a	consequence of):						
68760,	ate be ex hysician he burial	cal	(	d							
.89	tificate t ng physic as the b	ledi									
Box	leath certific attending p for use as 1	an/lv	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		☐ Ectopic pregnar	ncy			ate of delive	•
O. E	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)			IW.	OHUI	Day Year
P.O.	uires that the de signed by the a d be detached f		Part II. Other significant conditions o	ontributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use con	tribute to the	ne cause of death?
of Vital Records,	uires n sign lid be	d by	Rheumat	ic heart d	itease			10	Yes 2 No	3 ☐ Prot	oably 4 🗆 Unknown
00	sw requir s been s should	Completed						24a. Was		Were auto	psy findings available
R	The law ate has vage 2 s	mo						auto perfo	psy prmed? 2 No	death?	mpletion of cause of 2 □ No
ita	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only			
> \	hysic his ce i dire	10	1 Yes 2 No	Hospital: 1 Inpatier		nt 3 🗆 DOA		Home 5 ☐ Res	idence 6 □Ot	her <i>(Specit</i>	ý)
ū	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	y 28b. Time o (Year) Injury	Wo		28d. Describe	how injury occur	red	
isio	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be		ry - At home, farm, str		☐Yes 2☐No	28f Location /	Street and Num	her or Rurs	al Route Number,
Division	i or A after Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	cot, lactory, office			wn, State)	our or mure	ir rioute rumber,
	ospita hours inerai y filled			ysician: To the best o							
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page	Medical	one)	niner: On the basis of and manner stat				curred at the time			
	<b>10</b> With 20 Page 1	N N	29b. Signature and title of certifier	in Bech,	Mp	29c. Licer	46052		29d. Date signe	ed (Month,	
	a adu	$\mathcal{V}$							,	0	
	AND,		30. Name and address of person who	Completed cause of de	eath (Item 23a) (Type,	cal Park	way an	inapoli.	, Mo		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature						
	Registi	ar	JAN 2 3 200	19 Dereus	B. Spa	Med					

DHMH 17 Rev 1/2001

State Registrar				Cert	tificate of	Death		g. No. 200	04058
Decedent's Name (		,	-				2. Date of Death Month JANUARY		3. Time of Death
MILDRED I					4h Oihi Tours	ar I postion of Dooth	1		1;30P M
		ive street and nurr				or Location of Death		4c. County of De	_
ocial Security Num		Sex QUEEN	7. Age (In yrs. las	t birthday)	CENTRE If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	QUEEN .	irthplace (State or Foreign
2-78-320 al Residence of De	)4	1□M 2 <b>X</b> F	87	Yrs.	Months Days	Hours Min.	FEB. 16,	1921 M	ARYLAND
	0b. County		10c. City,	Town or Loca	ation				10d. Inside City Limits
RYLAND Q	UEEN AN	NE 'S	СН	JRCH H	ILL				1 □Yes 2 <b>X</b> No
Street and Numb					10f. Zip Code		10	g. Citizen of What	Country?
OO HALLM	IARK FAI	RM CIRCLE	3		21623			UNITED S'	TATES
farital Status  ☐ Never Married  ☐ Widowed 4		12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	e		as Decedent of Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	pecify Yes or No- po Rican, etc.)	14. Race - Ar Black, Wh Specify: W	
	5. Decedent's E	Education rade completed)		16a. Decede	ent's Usual Occu	pation during most of work	cina 1	6b. Kind of Busines	s/Industry
ementary/Second	, , ,	College (1-	-4or 5+)	lite. D	O NOT use retire  IEMAKER	ad)	,9	OWN HOM	E
Father's Name (Fi	irst, Middle, Las	st)				18. Mother's Nam	e (First, Middle, M	aiden Surname)	
WALTER S	STANLEY	COLE				LUCY M	ARVEL		
Informant's Nam	ne/Relationship	(Type. Print)		19b. Mailing	Address (Stree	t and Number or Ru	ral Route Number,	City or Town, State	, Zip Code)
AMES F.	HALL,	JR./HUSBA	AND CIAL	200 HA	LLMARK	FARM CIRC	LE, CHURC	CH HILL,	MD 21623
Method of Dispos		☐ Removal from S	State cen	netery, crem	ition (Name of atory or other pla	(ce) JANU	ARY 30	0c. Location - City	
4 ☐ Donation 5			CHUR		LL CEMET			CHURCH HI	
Signature of Fune	eral Service Lice	elfabe	0	FE) 408	LLOWS, E	ELFENBEIN LIBERTY S	I & NEWNAI TREET, CE	M FUNERAL ENTREVILL	HOME, P.A. E, MD 21617
		malications that cay		Do not ente	r the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between
nediate Cause (Fi		/ /	maham	//					Onset and Death
liting in death)	4	Due to (	or as a conseque	nce of):					1.101.111
		h							
uentially list condi ly, leading to immo se. Enter Underly	ediate III	Due to (	or as a conseque	nce of):				,	
se (Disease or inj initiated events	jury	С.							
Iting in death) Las	st	Due to (	or as a conseque	nce of):					
		d							
EMALE:  Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown		1 Live b	come of pregnand birth 2  Fetal d nant at time of dea own	eath 3 🗌	Ectopic pregnan Other (specify)	су		23d. Date of o	delivery Day Year
II. Other signification	ant conditions	contributing to de	ath but not resulti	ing in the un	derlying cause gi	ven in Part 1.	23e. Did toba	acco use contribute	to the cause of death?
VA. HT	W, Glu	are Into	lerance.	Hypoti	Moilis	$\eta$ ,	1 ☐ Yes	s 200 No 3 🗆	Probably 4 ☐ Unknown
A COL TON	115	1.	11	2010	2		246 Mas	24h M	outoney findings available
wai 471341	TILLENCY	, Yulmar	iary Hype	THENSI	vv		24a. Was an autopsy perform	prior 1	autopsy findings available o completion of cause of
PFracty	rsp &	ÖRIF			·		1 □Yes 2	No 1 □Y	
Vas case referred examiner?	d to medical	Hamitali			10.		th (Check only one	)	10/ 00/
I □ Yes No	0	Hospital: 1 □ I		R/Outpatient	3 LI DUA		ome 5 Resider		pecify) TOSPICE
Manner of Death  1 Natural  2 Accident	5 Pending investigati		of Injury 2 h, Day, Year)	8b. Time of Injury		iry at rk? ]Yes 2 □ No	28d. Describe hov	w injury occurred	,

**Physician** /Medical **Examiner** Examiner

(Check only one)

29b. Signature and title of certifier

, Day, Year

JAN29

29a. Certifier

Director

Be Completed by Funeral

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**Physician** 

/Medical

**Examiner** 

**Funeral** Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial

Medical Certification: To Be Completed by Physician/Medical

5/15

State

Registrar

31. Date

ed cause of death (Item 23a) (Type

32

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HARRISON ANUARY 21 2009 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HESTER RIVER HOSPITAL CENTER
Social Security Number 6. Sex 7. Age (In vrs. last birthday) KEN7 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ■ M 2 🔭 F 218-16-9102 Director 11-29-1924 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Keni md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21678 USA "natural", or items 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 10 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) ertified Nurse Assistant Self Employed marked other 17. Father's Name (First, Middle, Last) Ith and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie Cammile ပ Archie Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: If item 27 is any Injury or other trau Cutherine T. Boyer - Daughter 11561 St. 11 Pand Rd. Worton Md. 21678

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Tow 20c. Location - City or Town, State 20a. Method of Disposition Bigwords Cemetery U1-2.

22. Name and Addres of Facility
Bennie Smith Funeral Home
Rd 298, Chestertown, md. 21620 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 D Other (Specify) Worton Md. 21 Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART Physician FAILURE 5 days /Medical Due to (or as a consequence of): Examiner ARTERY DISEASE CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-trar and Due to (or as a consequence of): attending physician a for use as the burial Division or Vital Records, P.O. Box 68760, the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERIPHERAL ARTERIAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown CHRONIC KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform DIABETES MELLITUS Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No nours after death.
neral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours at To the Funeral C the Hospital 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

TLS

nestectown, maryland

22 Speer Road, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Noble.

31. Date filed (Month, Day, Year)

JAN 2 6 2009

## Baltimore, Maryland 21215-0036 JACK CALVIN HARRIS

	1 - For State Registrar			Certifica	ate of L	Death		Re	J. No.?	nna	0406	
ian	1. Decedent's Name (First, Middle,	Last)						Date of Death Month	Day	Year	3. Time of Death	
cai	JACK CALVIN HA			4h Ci	ity Town or	Location of I		ANUARY	15 4c. Co.	2009 unty of Death	3:30PM	
ner	4a. Facility Name (If not institution, 9690 CORDOVA R		1)	45. 01	EAST		Dour		10.000		LBOT	
			Age (In yrs. last bi	Month	der 1 Year hs Days		Min.	Date of Birth (Month, Day,	rear)	Cou	place (State or Forei	
	213–22–9979 Usual Residence of Decedent	A W 2	80	Yrs.			F	EB 8,19	928	MARY	TLAND	
	10a. State 10b. County		10c. City, Tov	wn or Location							10d. Inside City Limi	
ctor	MD TAI	LBOT		EASTO	N						1 □ Yes 2 <b>2</b> N	
Director	10e. Street and Number			10f.	Zip Code			10	g. Citizen	of What Cou	intry?	
	9690 CORDOVA	ROAD  12. Was Deceder	at Ever in II S	12 Was Do	216		n? (Specif	fy Yes or No-	14.	USA Race - Ameri	ican Indian.	
Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed Forces	s?				Puerto Ri	fy Yes or No- can, etc.)		Black, White,		
by F	3 ☐ Widowed 4 ☐ Wiovorced	If Yes, Give Year or Dates		1 ☐ Yes	s 2X No	Specify:			Sp	ecity: WH]	TTE	
ted	15. Decedent' (Specify only highes:		168	a. Decedent's U	work done of	during most c	of working	1	6b. Kind o	of Business/Ir	ndustry	
Completed	Elementary/Secondary (0-12)	College (1-4o		life. DO NO	T use retired	d)	9				row	
	17. Father's Name (First, Middle, L	Last)	E(	EQUIPMENT OPERATOR  18. Mother's Name (Fin.					CONSTRUCTION  (First, Middle, Maiden Surname)			
o Be	ALFRED HARRIS	/						TH COL		,		
2	19a. Informant's Name/Relationsh	nip (Type. Print)	19	b. Mailing Addr	ess (Street						ip Code)	
	DAVID M. HARRI	s/son	:	12565 B	LADES	ROAD,	CORI	OVA, M	216	525		
	20a. Method of Disposition	O D D Steen Steen	cemet	of Disposition (i	Name of or other place	ce)	Dat	e 2	0c. Locati	ion - City or T	Town, State	
	1 Nurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		16									
		pecify)	SPRII	NG HILL			1/21/	<b>/2009</b>   1	EASTO	ON, MAI	RYLAND	
	21. Signature of Funeral Service L	Licensee		22. Name	e and Addres	ss of Facility	BEIN	& NEWN	M FU	JNERAL	HOME PA	
	21. Signature of Funeral Service L	Ostrowshi	C.F.S.P	22. Name FELL 200	OWS, I S. HAI	ss of Facility HELFEN RRISON	BEIN ST.	& NEWN	AM FU	JNERAL	HOME PA D 21601	
	21. Signature of Funeral Service L osph m 23a. Part1. Enter the disease, or shock, or heart failure. List of	Complications that caus	CF.SP	22. Name FELL 200	OWS, I S. HAI	ss of Facility HELFEN RRISON	BEIN ST.	& NEWN	AM FU	JNERAL	HOME PA	
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Division or Vital Records, P.O. Box 68760,

To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th

2+VA

1 detailed in the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00046020

29d. Date signed (Month, Day, Year) 910

SYED I. ALI M.D.

31. Date filed (Month, Day, Year)

JAN 20 20 DUTCHMANS LANE, EASTON, MD 21601
Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Division of Vital Records, P.O. Box 6876	To the nospital or Attending rinysician. The law requires that the death certificate to within 24 hours after death
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for the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  For the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2[ 9 ☐ Unknown	! months? □No	1 4	Live birtl	me of pregna h 2 ☐ Feta it at time of o	al death		topic pregnanc ner (specify) _	у					ate of deliver	ery Day Year	
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To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caus and manner stated.  29b. Signature and title of certifier  29c. License number  29d.									e cause(	(s) and m	nanner as s	tated. the cause(s)				
To th within To th comp	29b. Signature and title of certifier  29c. License number  D.0057897								7	29d. D	ate signe	ed (Month,	Day, Year)	9			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** repuror 3000 /Medical County of Death 4a. Facility Name (If not institution. give street and number) 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F DEC 14, 1958 California Director 220-74-3196 50 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 □ No Director Maryland Cecil E1kton 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21921 United States 381 West Main Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗶 No Specify: Specify: Š 3 Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Stone Hauling Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph E. Jones, Sr. Mary A. Arrants ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Campbell/Companion 403 Park Circle, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 9 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery Elkton, MD 21. Signature of Funeral Service Licensee P.A. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or) attending physician and d for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 2 No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ should be 2 No 3 Probably 4 Inknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 NO or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 Thomicide City or Town, State) Hospital 24 hours 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOZNEG Do 600 North Wolfe St, Baltimore, MD, 21287 (FEORGE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 1 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Date of Death
 Month ONES **Physician** PER FURD INICCA 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 223 50 6377 **Director** 74 Aug 11,1934 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner is use the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Director VA Fauquier Warrenton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8035 Shipmadilly Lane 20186 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Jonathan Piper Virginia Rebecca Faulcon ၉ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20089 Boxwood Place, Ashburn, Sherri L. Jones Simmons VA 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moser Crematory Feb 7,2009 Warrenton, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Warrenton, VA fathlee Moser Funeral Home, 233 Broadview Ave, 20186 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, learning to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to for as a consequence of). The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknowf signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performed 2 No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 \_\_mpatient 2 ER/Outpatient 3 DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 🗌 No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and pragner stated. Signature and title of certifi

Registrar

DHMH 17 Rev 1/2001

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State

Name and address of perso

31. Date filed (Month, Day, Year)

1

ANNAPULIS WIDZIYUI

pleted cause of death (Item 23a) (Type, Print)

DA mn

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day2009 Year **Physician** Kunycia Nicolai 23,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vicamico Salisbury Rehaba Nursing Cto lisbun ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Year) 1 ★M 2 F 81 Months Days Hours Min 295-28-3510 Director 06/12/1927 Ukraine Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "naturel", or items 23a or 28a-f show event, the Modral Exercitor must be notified at Director 1 Yes 2 No Maryland Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21871 **IISA** 7148 Old Westover Marion Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 X Widowed 4 Divorced white N(CO|Q) KUU Baltimore, Maryland 21215-00 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk agriculture farmer unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental tem 27 Is marked o Pages 1 and 2 should be nent of Health and Mental item 27 is marked other traumatic ev Wekla (unknown) Ivan Kunycia ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Snow Hill Rd., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) John Holloway/funeral director 20b. Place of Disposition (Name of Sternel Flace) 20c. Location - City or Town, State 20a. Method of Disposition Date Important: If it eny Injury or o once. 1/30/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State South Bound Brook, NJ Department 4 ☐ Donation 5 ☐ Other (Specify) Orthodox Church Cemetery 21. Signature of Funeral Service Lieensee 222 Name and Address Fifacility of Professional Association Kall 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heart **Physician** Congestive disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or Examiner Physician: The law requires that the death certificate be executed viabet burial-trar resulting in death) Last P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 No 2 🗆 No of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Ho Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 FMatural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 10059931 30. Name and address of person who completed cau e of death (Item 23a) (Type, Print) Hofmann M.D. 304343Mt. VernonRd. Princess Anne, MD 21853 ·Dre th, Day, Year) Year) 32. Rygistrar's Signature State 8

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Registrar

09-00835 Kenneth Keller Please Type or Print in Black indelible into Ensure All Copies Are Legible FH G890 4/8/09 dk

Threat Rener		I- For State Registrar	•	cate of Death	- Wertar	Re	g. No. 200	9 1616			
Physicia edical Exami	_	1. Decedent's Name (First, Middle,Last)  Kenneth E. Keller Jr.				2. Date of Death Month January 28	Day Year 3, 2009	3. Time of Death			
ز		4a. Facility Name (if not institution, give street and number) Western Maryland Healtgh System		4b. City, Town, c Cumberlar			4c. County of Deat Allegany	ĥ			
Funeral Director		213-76-5652 1XM 2F	(In yrs. last b	rthday) If Under 1 Ye Months Da		Hrs. 8. Date of Birti Min. April	7,1966 Forei				
any		Usual Residence of Decedent  10a. State 10b. County			10d. Inside City Limits						
faryland 28a-f show 1 at once.		MD Allegany  10e. Street and Number		La 10f. Zip Code	Vale	I 10	g. Citizen of What Co.	1 X Yes 2 No			
th the Mar. 23a or 28a notified at	Director	120 Mustophal Drive			1502		USA	инд у ?			
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygievier.  Intell Filem 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 22	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba			14. Race - Ame White, etc.	rican Indian, Black,			
s after ( rral", o	ρ	3 Widowed 4 X Divorced of Page 14 Yes, Give Year or Dates:		1 Yes 2 X N		l of work done	Specify: Wh				
72 hours af n "uatural al Examin	eted	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5		during most of working lif	e. DO NOT use	retired)	Tob. Killa of busiless	Andustry			
5-0036 ted within 72 tygiene. other than '	Completed	12		carpet insta		ame (First, Middle, M	Custom Ca	rpets			
21215- uld be filed Mental Hyg marked old	Be C	17. Father's Name (First, Middle, Last)  Kenneth E. Keller Sr.				•	enstein Ta	ylor			
D 21 should I and Mei	٥	19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailing Address (Stre 120 Mustopha							
e, MD 2 and 2 shou Health and N item 27 is n		Jo Ellen Taylor/Mother  20a. Method of Disposition		e of Disposition (Name of c		Date	20c. Location - City of				
altimore, rmit. Pages I ar spartment of Her portant: If ite		Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	ile	ratory or other place)	.   1	/30/2009	Cresaptow	m, MD			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service Licensee  James F. Scarpelli per DVR		22. Name and Addre	ss of Facility	Scarpe11	i Funeral	Home			
Physician		23a. Part I. Enter the disease, or complications that caused					erland, MD est, shock, or heart	Approximate Interval			
Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic		cular Disease				Between Onset and Death			
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
	niner	if any, leading to immediate Due to (or as a consequence of):									
ted 1 Insit	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.									
760, Grate be executed g physician and the burial - transit	Medical	UNPENDED X AMENDED #1	as no	ted per ME g	889 3/9	/09 TT					
Division of Vital Records, P.O. Box 68760, within 24 fours and retrificate be executed within 24 fours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed by Physician/Me	by Physician/	sician/	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown g Unknown	ne of pregnand	2 Fetal death 3 5 Other (Specify)	Ectopic pro	egnancy	23d. Date of delive Month	Pry Year
, P.O. E ires that the c signed by the be detached			Part II. Other significant conditions contributing to death	but not result	ting in the underlying cause	given in Part I.		bacco use contribute t	o the cause of death?		
Division of Vital Records, P.O. In or Attending Physician: The law requires that the nar detend.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach						24a. Was a autop	sy prior to med? death?				
tal Rectian: The certificate ector, page		25. Was case referred to medical		26.Pla	ce of Death (Ch	1 Yes leck only one)	2 No 1 🗸 `	Yes 2 No			
F Vite	To Be	Tes 2 No	U - WU	Outpatient 3 DOA			Residence 6 Oth	er:			
on of nding Pl tth. r: After re funeral	tion:	27. Manner of Death  1 V Natural  5 Pending  28a. Date of Inju (Month, Day,Y)	ear)		jury at Work? Yes 2 No	1	now injury occurred				
Divisior al or Attend s after death il Director: ed in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Division of Vital Rec To the Hospital or Atending Physician: The within 24 hours after death. To the Funeral Director: After this certificate! completely filled in by the funeral director, page		29a. Certifier (Check only one)  Wedical Examiner: On the basis of example of the control of the									
To t with To t	Medical	and manner stated.  29b. Signature and title of certifier			nse number		29d. Date signed (M				
		Mla Brane (, M)	5	0.0	C.M.E.		January 29, 200	09			
		30. Name and address of person who completed cause of of Melissa Brassell, MD Assistant Medical			Baltimore. I	MD 21201					
<u>.</u>	tate	31. Date filed (Month, Day Year) \$ 1 000 32. Registra	re Signature	B. Jakel							
Regis	trar	FED 2003 /20	Wall and the same	10.							

DK

Please Type or Print in Black Indelible Lyk 1 Fragure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 23°0 M **Physician** Paul ROBERT KENAWEL 2669 FEBRUARY OZ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 □ F Director 189-34-5850 July 10, 1943 Hollidaysburg, Usual Residence of Decedent or 28a-f show notified at the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Washington Hagerstown 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6 ms 23a or must be r 312 Hollymead Terrace 21742 Funeral US death 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 → No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status r than "natural", or ite the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2x No ģ Specify White 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) soldier Federal govt. other 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be marked Ernest Kenawell Catherine Zeek ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 Judith Ann Kenawell 312 Hollymead Terrace Hagerstown, MD 21742 Department of Heal Important: If Item 2 any Injury or other once. 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 X Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/4/2009 4 Donation 5 Other (Specify) Cumberland Valley Crematorium Waynesboro, PA 21. Signatore of Funeral Service Licenses 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. XWL 50 S. Broad St. Waynesboro, PA Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a conseque of): years disease or condition resulting in death) artery /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 TEctopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 2 No 3 Probably 4 Unknown Completed certificate has been sig lirector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 2 No 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. 2 Accident by the f Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after Direc 4 Homicide filled in within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

STALL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

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29d. Date signed (Month, Day, Year)

2009

FEBRUALY 03

600 North Wolfe St, Baltimore, MD, 21287

12 DK **Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

Directo

Funeral

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Completed

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1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran s been signed by to should be detach

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	disease or condition resulting in death)	a. Du lo (or as a consequence of):	ction								
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	quentially list conditions, may be a consequence of):  b. Consesting to immediate use. Enter Underlying use (Disease or injury ti initiated events  c. or Maccel Employeemen									
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year						
ed by Pr	Part II. Other significant conditions of		use contribute to the cause of death?								
Sompleto	adviced deli	~ux		24a. Was an autopsy performed? 1 Yes 2 X N							
Be (	25. Was case referred to medical	-	26. Place of D	eath (Check only one)							
ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)						
tion: ]	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	cribe how injury occurred						
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	and Number or Rural Route Number, te)							
Medical Certification:	29a. Certifier (Check anly one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day,  126/09										
	30. Name and address of person who	completed cause of death (Item 23a) (Type, Pr	ansi, Eashan,	ND 216	01						
te ar	31. Date filed (Month, Day, Year) JAN 2 7 200	32. Registrar's Signature									

Registrar DHMH 17 Rev 1/2001

State

81 VA

within 24 hours a To the Funeral I

725

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #19a 1 - State Registrar TCHD, 02/06/2009, TLS Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** JAMES THOMAS LEE 2009 7:10 AM Jan /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Easton Talbot 8. Date of Birth (Month, Day, Year)
APR 6, 1924 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral X** M 2□ F 84 Director 056-18-4709 NEW YORK Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10h. County 1 ☐ Yes 2X No Director MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a 9809 GREGORY ROAD 21601 USA within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □X'es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married ames Lee Baltimore, Waryland 21215-0036 1 ☐ Yes 2 ▼No Specify. WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) g 12 PHOTOGRAPHER PRINTING COMPANY Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, If once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental PATRICK J. LEE JANE GRACE ျှ 19a. Informant's Name/Relationship (Type. Print) ADRIANNA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9809 GREGORY ROAD, EASTON, MD 21601 ADRIANA LEE/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ST. JOSEPH'S CEMETERY 1/28/2009 4 ☐ Donation 5 ☐ Other (Specify) CORDOVA, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee MOHO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart Concertwe Physician disease or condition resulting in death) /Medical Due to (or and consequence of): Examiner sertensive LOS sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 2 No P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 W Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Division or Vital** I or Attending I after death.

To the Hospital within 24 hours a To the Funeral Completely filled in TLS Gt VA

and manner stated.

29c. License number 442587

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

01-22-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 Cynwood N Gaston MD 2168

31. Date filed (Month Registrar

29b. Signature and title of certifier

29a. Certifier (Check only one)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For Registrar AMEND#19bperFF	State of Marylar H1/29/09, BM, McCo	nd / Depa	artment of F			giene 0 0	9 04070			
Physic	cian	1. Decedent's Name (First, Middle, La					2. Date of Dea Month	Day Y	3. Time of Death			
/Med	ical	ANTONINA 18CO			4b. City, Town, o	r Location of De	ath	4c. County of				
Exam	iner	Brocke Grove Rehabilitat		nter	Sandy	Spring	1	Montgo				
Funera		5. Social Security Number 6. S	Sex 7. Age fin yrs.		If Under 1 Year Months Days	If Under 24 H						
Director		5/9-62-69/3	<sup>1□M 2</sup> 85	Yrs.	Worth Days	Tiodis in	Dec. 1		Italy			
and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits			
Maryl 1 sho	ō	Maryland Mont	gomery	Olney	•				1 ☐ Yes 2 🕱 No			
h the	Director	10e. Street and Number	gomery	Olifey	10f. Zip Code			10g. Citizen of Wha	at Country?			
ath wit		18601 Thornber	ry Lane			0832		USA				
be filed within 72 hours after death with the Marylan tal Hyglene.  Id other than "naturel, or items 23a or 28e-f show event, the Medical Evant and matter the notified at	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Black, '	American Indian, White, etc.			
rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>万秋</b> 0 If Yes, Give Year or Dates:		1 ☐ Yes 2√€ No	Specify:		Specify:	White			
2 hou		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	ess/Industry			
thin 7	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	d) most or v	working					
led wi lyglen her th		5		Sea	mstress_	10 Markada N	Inma /Fires Adidate	Clothi	ng			
lbe fi	Be	17. Father's Name (First, Middle, Last Francesco Borse	_				Name <i>(First, Middl</i> e, on <b>i</b> na Scal					
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.  is markad other than "naturel", or items 23a or 28e-f show eumatic event, the Medical Exambles must be notified at	ဥ	19a, Informant's Name/Relationship (		19b. Maili	ng Address (Street				ate, Zip Code)			
C, INCL ) IC s 1 and 2 should f Health and Mer item 27 is merks	1	Vince Iacono/Son	· · ·	186	01 Thorn	perry La	ane, Silv	ey Fr Spring	, MD 20832			
00	-	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	osition (Name of matory or other plac	сө) Ja	Date	20c. Location - Cit	y or Town, State			
permit. Pag Department Importent: I any injury o		`4 □Donation 5 🖾 Other (Special	y) entombment		f Heaven		- 2003		pring, Marylan			
permit. Pag Department importent: I any injury o		21. Signature of Funeral Service Lice	nsee	L. Contract			ns Funera					
Physician		23a. Part1. Exter the disease, or com shock, or eart failure. List only Immediate Cause (Final disease or condition	nplications that caused the deal one cause on each line.	th. Do not en	ter the mode of dyir	ng, such as card	liac or respiratory ar	Silver S rest,	Approximate Interval Between Onset and Death			
/Medica Examine		resulting in death)	Due to (or as a consec				,		1100125			
pe tis	iner	Sequentially list conditions, if any, leading to immediate sauss. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):								
cate be executed obysician and the burial-transit	I Examin	that initiated events resulting in death) Last	C	quence of):			<u> </u>					
icate b	dica		_ d									
ath certif	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 2 No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   1   Unknown   5   Other (specify)   1   The past 12 months   1   The pas						23d. Date o Month	Birthplace (State or Foreign Country)  Italy  10d. Inside City Limits 1			
res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?			
w require been sig		ADVANCED DE	MENTA				1 🗆 Y	es 2 No 3	☐ Probably 4 ☐Unknown			
law requase been 2 should	Completed						24a. Was		re autopsy findings available			
The The ate his page	lo E						perfo	rmed? dea	th? Yes 2□ No			
vical IICO rsicien: The law s certificate has b lirector, page 2 s	Be (	25. Was case referred to medical examiner?			7.5		Death (Check only o					
tending Physicien: The leath.  for: After this certificate his the funeral director, page	6	1 Tes 2 No		ER/Outpatier	The second second	4 Mursing	g Home 5 Resid	lence 6 Other (	(Specify)			
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or Attending Physicien: ifer death. Director: After this certifica in by the funeral director, I	Certification:	3 Suicide 6 Could not to determined	De 290 Plans of Injury At h	nome, farm, st	reet, factory, office		28f. Location (S City or Tox		or Rural Route Number,			
To the Hospitei or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tu			hysician: To the best of my kno									
the H hin 24 the F	Medical	one)	and manner stated.		29c. Licens							
5 N S S	-	29b. Signature and title of certifier	ATTENDING PH	4451611	-	4204	6	1				
)		30. Name and address of person who	completed cause of death (Iter			Sand	y Spine	Manlan	1 20860			
	tate	31. Date filed (Month, Day, Year)	22 Registrar's Sign		Cray pare		1-1-1-1	100				
Regis	trar	JAN 28 20	109 Perme	M. MA	Les of							

			For State Registrar	State of Mar	-				eann a Death	aliu iv	, ,	eg. No.2	0.00	01.071	
		-1	Registrar     Decedent's Name (First, Middle, Las	t)							2. Date of Deat	h	JUJ	3. Time of Death	
p.F.	Physici /Medic		Lawrence Wade	Moreland							January	22,	2009	0445 M	
100	Examir	_	4a. Facility Name (If not institution, give	street and number)					Location of				nty of Death		
<u>.                                    </u>			Calvert Memoria  5. Social Security Number 6. Se		(In yrs. last birth	hday)	Pr If Under		Fre		CK 8. Date of Birth	C	alvert	lace (State or Foreign	
in the state of th	Funeral Director			XM 2□F		rs.	Months	Days	Hours	Min.	Month, Day, Dec. 4,		Coun	ington, DC	
Ind 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show	ne Maryland Ba-f show ptified at	Director	10a. State 10b. County  MD Calve		Oc. City, Town									0d. Inside City Limits 1 ☐ Yes 21 No	
	with the		10e. Street and Number				10f. Zip		OCE TO		10		of What Cour USA	itry?	
	eath	eral	50 Appeal Lane  11. Marital Status	12. Was Decedent Ev	er in U.S.	13. W	/as Deced		0657	ain? (Spe	ecify Yes or No-		Race - Americ	an Indian,	
5-0036	should be filed within 72 hours after death with the Marylar and Mental Hygiene. marked other than "natural"; or items 23a or 28a-f show marked other than "datical Examiner must be notified at	by Funeral	1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates:			Yes, spec		n, Mexicar Specify:	n, Puèrto	ecify Yes or No- Rican, etc.)	E	Black, White, ecify: Whi	etc.	
2	72 ho natur dicai l	eted	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. I	(Give k	ent's Usua	k done d	lurina mos	t of worki	ng	16b. Kind of	Business/Ind	dustry	
Maryland 2121	d within giene.	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. D	o not us ager	e retired				Groc	ery/Re	tail	
p	be filed tal Hygi d other event, ti		17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle, N	Aaiden Surr	name)		
<u>Ş</u>	should I and Men marker umatic	유	James H. Morela:		106	Moiling	Address	(Stroot d	Ev				un Chata Zia	Codel	
<u>a</u>	d 2 sho th and t7 is ma traum						• Box			sby,	al Route Number MD 206		vn, State, Zip	Code)	
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic once.		Jonathan Moreland  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of cemetery  Maryla	Disposi y, crem	ition (Nan atory or o	ne of ther plac	e)	Jan 20	<sup>Daţe</sup> 30	20c. Locatio	enham		
Baltii	permit. Pag Department Important: i any injury o		21. Signature of Emeral Service Licen	see	India, y and	22.	Name an	d Addres	s of Facili	<sup>ty</sup> Lee	Funeral	Home	Calve	rt, PA	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Circlet and Death Circlet and Dea										Approximate Interval Between		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Meta  Due to (or as a	astatic consequence o		ncrea	tic	Canc	er				3.5 mos	
A		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
oʻ	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	Due to (or as a consequence of):										
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P.O. Box	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	☐ Fetal death		Ectopic pr Other (sp						Date of delive Month	ory Day Year	
	s that ned b e deta	by Pr	Part II. Other significant conditions of	ontributing to death but	not resulting in	the und	derlying ca	ause give	en in Part I		23e. Did tob	acco use c	ontribute to th	ne cause of death?	
ğ	w require been sig should b	ed b	Pulmonary Embol	i							1 □ Y∈	es 2 No	o 3⊠ Prob	ably 4 ☐Unknown	
Vital Records,	The law recate has been page 2 sho	Completed	Atherosclerotic	Heart Dise	ease						24a. Was autops perform	ned?	death?	psy findings available npletion of cause of	
ta	W DT		25. Was case referred to medical						26 Place	of Death	1 Yes 2 1 (Check only on	P XNo	1 🗆 Yes	2∐ No	
	ysician: nis certifica director, p	o Be	examiner? 1 □ Yes 2₩ No	Hospital: 1  Inpatient	2 <b>g</b> ER/Out	patient	3 🗆 DO	A Othe	er-		me 5 ☐ Reside		Other (Specif	y)	
o uo	ding Pi n. After th funeral	tion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Ti	ime of jury	M 2	8c. Injury Work			28d. Describe ho			<u>.                                    </u>	
Division or	al or Atten after death i Director: d in by the	Certification:	3 Suicide 6 Could not be determined			m, stre	et, factory				28f. Location (St. City or Town	reet and Nu , State)	imber or Rura	l Route Number,	
	o the Hospital or ithin 24 hours afte to the Funeral Dir ompletely filled in I	Medical C		ysician: To the best of niner: On the basis of e and manner state	xamination and										
	o the vithin 2 o the complet	Me	29b. Signature and title of certifier				290	. License	number		2:	29d. Date signed (Month, Day, Year)			

Kenneth L. Abbott, MD 110 H
31. Date filed (Month, Day, Year)

JAN 28 2009

32. Registrar's Signature State

Barrel J

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D56024

110 Hospital Road Ste 110 Prince Frederick, MD

23 January 2009

20678

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Of IVIAI	ryland / Depa <i>Ceri</i>	tificate of l		ientai riyg Re	eg. No 2009	04072			
	Physicia	an	1. Decedent's Name (First, Middle, Last) Billie Smith McDonald	Day Year 24, 2009	3. Time of Death  22:04							
de.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	Location of Death	January	4c. County of Dear	122:04					
			Washington Adventist Hospit	Park  If Under 24 Hrs.	8. Date of Birth	Prince G	eorge's thplace (State or Foreign					
	Funeral Director		260-60-1087 1XIM 2 F	Year) Co	orgia							
Maryland a-f show		ctor	10a. State 10b. County	10c. City, Town or Loc Lusby	eation	tion			10d. Inside City Limits 1 □Yes 2XNo			
h with the	th with the 23a or 28 at be not	Funeral Director	10e. Street and Number 11354 Tomahawk Trail		10f. Zip Code 20657			og. Citizen of What Co United Sta	,			
5-0036	within 72 hours after death with the Maryland sien. siene. r than "natural", or items 23a or 28a-f show the Maryland Evan, in a nationalities and the Maryland State of the Mary	ρ	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 Married Married Married Married Fres, Give Year or Dates:	1939-	Vas Decedent of H Yes, specify Cuba □Yes 2 XNo	ispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:				
0-c L	in 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup kind of work done of ONOT use retired	ation during most of worki f)	ng	16b. Kind of Business	Industry			
212	filed within 72 Hygiene. other than "nai ent, II. W. dia	Com	Elementary/Secondary (0-12) College (1-4or 5+)	)   .	t Engine	er		Aviation				
and	be od o	To Be (	17. Father's Name (First, Middle, Last)  Charles A. McDonald			18. Mother's Name Beulah S		Maiden Surname)				
Maryland	s 1 and 2 should I of Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Agnes G. McDonald (Wife)			and Number or Rura	al Route Number	, City or Town, State, 2				
ָרָ נָּים	Pages 1 and nent of Health int: If item 27 iry or other ti		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos				20c. Location - City or				
altın	permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Arlington 22.	National Name and Address			Arlington, uneral Hom				
n		5 0	st. g. Sitt	Į.				land 20657				
8 <u>.</u> 1	Physician	98	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Industrial Cause (Final Industrial Cause)  Approximate Interval Between Onset and Death Onset Industrial Cause (Final Industrial Caus									
	/Medical Examiner	iner	resulting in death)  Due to (or as a consequence of):									
	⊅ ±		Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury									
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	at the d	Phys	9 □ Unknown		dedide i	on in Don't	22a Did toh	20 000 use contribute to	the cause of death?			
rds,	requires that the peen signed by th hould be detache	5	Renal jadure						cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown			
Vital Records,	: The law re cate has bee page 2 sho	ompleted		autopsy								
<u>a</u>		O	25. Was case referred to medical	2. ☑•No 1 ☐ Yes	2 □ No							
	Physician: rthis certific ral director,	To Be		t 2 ER/Outpatient	t 3 □ DOA Oth	er: 4 ☐ Nursing Ho		ence 6 ☐Other (Spe	cify)			
ono	Fe Te	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 8 Nork?  M 1 Yes 2 No  28d. Describe how injury occurr									
=	5 ± ± ⊂	Certification:	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Num City or Town, State)									
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or inv	occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)			
	Vithir Comp	Me	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Mont	· · · · · · · · · · · · · · · · · · ·			
	1200	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MUHANIMAD ASHRAF, 5711 Saivin avenue #100 Riverdali, MD 20										
			MUHANIMAD ASHRAF,	5711 Sai		nue # 100	, Kiu	verdali, MD	20737			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar	1. parker	/							

ondod :	ito		of Maryland / De	ndelible lnk. Ensure A partment of Health and l ertificate of Death BA	Mental Hygier	ne 2009 01.073
Physici: /Medic	an	1. Decedent's Name (First, Middle, Last)  John Robert Motes			2. Date of Death Month Jan. 24,	2009 Year 2:59 P M
Funeral Director	ier	4a. Facility Name (If not institution, give street and not Atlantic General Hosp 5. Social Security Number 6. Sex 150 M 2 F F Usual Residence of Decedent	7. Age (In yrs. last birthda 7. 79	Months Days Hours Min.	8. Date of Birth	1929 North Carolina
ne Maryla 8a-f shov	Director	MD Worcester	10c. City, Town or Ocean Ci	ty		10d. Inside City Limits 1 ☑ Yes 2 ☑ No
ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show attc event, it is in cifes Examirat nutrit to inciffic of	by Funeral Dire	Armed F	<sup>2□No</sup> 1947	10f. Zip Code  21842  3. Was Decedent of Hispanic Origin? (Solf Yes, specify Cuban, Mexican, Puerton 1 □ Yes 2√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√		USA  14. Race - American Indian, Black, White, etc.  Specify: white
thin 72 hour le. <b>an "natural</b> Medical Ex	Completed I	15. Decedent's Education (Specify only highest grade completed)	1530   16a. De	cedent's Usual Occupation ve kind of work done during most of wor DO NOT use retired)		Kind of Business/Industry search and Developme
be filed wil ntal Hygien ed other th event, Inc	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	ealth Care en Surname)
is 1 and 2 should be filed of the state and Mental Hyging them 27 is marked other other traumatic event, in	2	Mason Motes  19a. Informant's Name/Relationship (Type. Print)  Mary Jayne Motes - wife	I	Dessie ulling Address (Street and Number or Ru DI Tunnel Ave. #1A	-	
permit. Pages 1 ar Department of Hea Important: If Item : any injury or other once.		20a. Method of Disposition  1 Derivation 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	State 20b. Place of Dis	position (Name of rematory or other place)	28, 09 Ber 128, urbage Fune	lin, Maryland ral Home
Physician /Medical Examiner		23a. Party. Enter the disease, or complications that shock, or heart failure. List only one cause in Immediate Cause (Final disease or condition resulting in death)  a	caused the death. Do not deach line.  (or as - consequence of):			Approximate Interval Between Onset and Death
be executed iician and burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):		_ =	
the death certificate y the attending physiched for use as the t	Physician/Medic	in the past 12 months?	nant at time of death	3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
been signed by the should be detached	출	Part II Other significant conditions contributing to d	leath but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
ate has	Be Completed	25. Was case referred to medical examiner?		26. Place of Dea	autopsy performed?  1 □ Yes 2 □	prior to completion of cause of death?
The translation of Artendary Proportion. The taw requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification: To E	1 Yes 2 1 1 2  27. Manner of Death 1 Natural 5 Pending investigation investigation	inpatient 2 ER/Outpat of Injury oth, Day, Year) 28b. Time Injury e of Injury - At home, farm, ing, etc. (Specify)	of 28c. Injury at Work?  M 1 Yes 2 No	ome 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta	ury occurred  and Number or Rural Route Number,
ne nospitat n 24 hours he Funeral pletely filled	edical Co	(Check only 2 Medical Examiner: On the	e best of my knowledge, de pasis of examination and/or oner stated.	eath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause arred at the time, date a	e(s) and manner as stated.  Indicates and due to the cause(s)
To the confidence of the confi	Me	29b. Signature and title of certifier	~ ~~	29c. License number 0 645 85	29d. [	Date signed (Month, Day, Year)
910+1		30. Name and address of person who dempleted cau	se of death (Item 23a) (Typ	Print) M AN	hom Der	rila

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ann Month Manck /Medical 3:19 PM January 22 2009 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2XX Director 60 219-54-4192 7/1/1948 MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Rem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be marked. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Anne Arundel Annapolis 1 Yes X No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 117 Conduit St. Funeral 21401 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: δ 3 Widowed 4 Divorced 1 Yes 2 No Specify. White Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary County Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Melvin Schlossman Ruth Greengold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Manck Spouse 117 Conduit St. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kneseth Israel 1/25/2009 | Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12 Ridgely Ave. Annapolis, MD 21401 Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Stroke Onset and Death 9 0/95 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) ician and burial-trans resulting in death) Last Due to (or as a consequence of): signed by the attending physician id be detached for use as the buris Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 2 Fetal death Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? Completed 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perforn 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? s after dea....al Director: After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (check only To the I 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

600 N. WOLFE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Koenig

JAN 27 2009

Matthew

31. Date filed (Month, Day, Year)

29c. License number

00063682

29d. Date signed (Month, Day, Year)

January 22,2009

Balkinon600 North Wolfe St, Baltimore, MD, 21287

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show

5	Phy /M Exa	sic edi
	rted	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director: After this certificate has been signed by the attending physician and

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	4 ☐ Donation 5	Other (Specif	ý)	Capi	itol Ćr			17-09	DOV	er,	ре		
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		State Registrar					ertificate of	Death		Reg.	No. 2009	1 040/6		
Physicia	ın		e (First, Middle, La	,					2. Date of Month		Day Year	3. Time of Death		
/Medic		William		Maloy			Tu a: *			January 22, 2009   10:30 A <sup>M</sup>				
Examin	er	,		e street and number)			4b. City, Town, o		th		4c. County of Dea			
Funeral		Arden Co  5. Social Security N		ex 7. Aq	e (In yrs. la	ast birthd		If Under 24 Hrs	8. Date of	Dirth	Montgome:	thplace (State or Foreign		
Director		133-22-7	1 1	MM 2□F	8		Months   Davs	Hours Min	Sept	Day, Ye	ear) Co	York		
70		Usual Residence o	f Decedent					1	1					
show	-	10a. State	10b. County		10c. City	, Town o	r Location					10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
8a-f	ecto	MD	Montgome	ery	Silv	er S	pring			1				
with ti		10e. Street and Nu		1			10f. Zip Code				. Citizen of What Co	ountry?		
eath v	Funeral Director		grove Roa	12. Was Decedent	Ever in 119	2 .	20904	lispanic Origin? (	Specify Ves or	US	A 14. Race - Ame	arican Indian		
ter d	Fun	11. Marital Status 1 □ Never Marr	ried 2 Married	Armed Forces?		.	<ol> <li>Was Decedent of H If Yes, specify Cub.</li> </ol>	an, Mexican, Pue	rto Rican, etc.)	140	Black, Whit			
urs a	þ	3 X Widowed		If Yes, Give Year or Dates:		46	1 □ Yes 2 No	Specify:			Specify: Wh:	ite		
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i be fi	Be	Robert M						Laura H	,	uie, mai	den Sumame)			
I an include the Maryland 2 should be filed with the Maryland 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 12 hours 23a or 28a-f show animatic event, the modified Evaning must be notified at	욘		ane/Relationship (	Type, Print)		19b. M	ailing Address (Street			mber. C	ity or Town. State.	Zin Code)		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene.  Department of Health and Mentall Hygiene.  By any injury or other traumatic event, the medical Examination with be notified at once.				/daughter		1	inehurst C					'		
Item Star	-	20a. Method of Dis			20b. P	ace of Di	sposition (Name of crematory or other place	ce)	Date	200	c. Location - City or	Town, State		
t. Pages tment of tant: If It jury or o			Cremation 3 □     5 □ Other (Specife	Removal from State			del Cremat	:	23/09	Od	lenton, Ma	arvland		
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D 88 E 8 8		12e	als Xh	alitte	MO1	251	Beverly L.	Heckrot	te. P.	4. C	larksvil	le. MD 21029		
		23a. Part 1. Enter to shock, or hea	the disease, or com art failure. List only	plications that caused one cause on each li	d the death	. Do not	enter the mode of dyi	ng, such as cardia	ac or respirator	y arrest	,	Approximate Interval Between		
Physician		Immediate Cause disease or condition	on	Alzheim	er's	Dise	ase					Onset and Death		
/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):								
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the at	sici	1 ☐ Yes 2	□No	4 ☐ Pregnant a 9 ☐ Unknown	at time of d	eath	5 Other (specify)	-		_	Month	Day Year		
hat the sed by detacl				contributing to death b	out not resu	Itina in th	e underlying cause giv	en in Part I.	23e. D	id tobac	co use contribute to	o the cause of death?		
requires t	d b			3		. 3	,		1	☐ Yes	2 XNo 3 ₽	robably 4 Unknown		
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he lay e has	dmo								a	utopsy erformed s 2X	prior to	completion of cause of		
an: T an: T tifficat for, pa	0	25. Was case refe	rred to medical					26. Place of De			No 1 □Yes	s 2□No		
Physician; The Is this certificate har rail director, page 2	To B	examiner? 1 ☐ Yes 2 <b>X</b>	No	Hospital: 1 ☐ Inpatie	ent 2	ER/Outpa	atient 3 DOA Oth				e 6 Dother (Spe	assisted		
ng Ph		27. Manner of Dea	th 5 Pending	28a. Date of Inju	ury ay, Year)	28b. Tim Inju					injury occurred	,		
tendi eath. or: A	catio	2 Accident	investigation 6 ☐ Could not b	n			M 1	Yes 2 □ No						
or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined		ury - At ho tc. <i>(Specif</i> )	me, farm	, street, factory, office		28f. Locatio City or	n <i>(Str</i> ee To <i>wn, S</i>	et and Number or R State)	ural Route Number,		
pital purs a eral C	- 1	29a. Certifier	1) Certifying Pi	weiging: To the heet	of my kno	wledge o	leath occurred at the t	imo, data and pla	and due to	the cour	oo/o) and manner a	e stated		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)	2☐ Medical Exa	niner: On the basis of and manner st	of examina	tion and/	or investigation, in my	opinion, death oc	ce, and due to curred at the tir	ne, date	and place, and du	e to the cause(s)		
To the	Me	29b. Signature and	the of certifier	1 1/-			29c. Licens	se number		29d.	. Date signed (Mon	th, Day, Year)		
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57/00		•	- 11		4 01		e Ave. Lau	rel, MD	20707					
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			. For		State o	of Mai	ryland	/ Depa	rtment of H	lealth	and N	lental Hy	giene			
			State Registrar					Cer	tificate of L	Death		F	Reg. No.	2009	040	77
	Physicia	ın	1. Decedent's Name (First, Mi	ddle, Las	t)		3.1					<ol> <li>Date of Dea</li> <li>Month</li> </ol>		200 <sup>year</sup>	3. Time of D	
	/Medic		Dolly	Ma			Mose	er				January	<del></del>			Рм
	Examin	er	4a. Facility Name (If not institution Northampton	-			are		4b. City, Town, or	Location of erick				County of Death Frederi		
	Funeral		5. Social Security Number	6. Se			(In yrs. las	st birthday)	If Under 1 Year	If Under		8. Date of Birt		9. Birth	place (State or	Foreign
	Director		214-32-9991		⊐м 2Юг		77	Yrs.	Months Days	Hours	Min.	Aug. 3,	193	31 Mary	iptry)	
	p.		Usual Residence of Decedent													
	arylar show	'n	10a. State 10b. Cou					Town or Loc	cation						10d. Inside City 1 ☐ Yes 2	
:	28a-f	Director		leric	K		Mt. A	liry	10f, Zip Code				10- Citi	zen of What Cou		
	a or		10e. Street and Number 5430 Sidney Ro	had					21771				USA	zen or what cot	iriti y r	
	ns 23	Funeral	11. Marital Status	au	12. Was Dec	edent Ev	ver in U.S.	13. V	Vas Decedent of Hi	ispanic Or	igin? (Sp	ecify Yes or No-		14. Race - Amer	ican Indian,	
	or iter		1 Never Married 2 N	Married	Armed Fo	2 <b>Z</b> No	0	1	Yes, specify Cuba ☐Yes 2XNo	in, Mexica: Specify:		Rican, etc.)		Black, White	, etc.	
3	iral",	d by	3 XWidowed 4 ☐ Divor	ced	If Yes, G Year or [				163 22110	ореспу.					ite	
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2	filed Hygi other ent,		17. Father's Name (First, Mide	dle, Last)				110111011		18. Moth	er's Name	e (First, Middle,				
5	lid be lental rked o	To Be	William Marsha	ί11						Clec	Smi	th				
a	2 should be filed within 72 hours after death with the Maryland and Memberla Hygiene is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations to notified at	-	19a. Informant's Name/Relati	onship (7	Type. Print)			19b. Mailin	g Address (Street a	and Numb	er or Rur	al Route Numbe	er, City or	r Town, State, Z	ip Code)	
	and 2 ealth m 27 i		<u>Patti A. Marsh</u>	ıa11/	execut	<u>rix</u>			Sidney R							
	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremati	on 3□	Removal from	State			sition (Name of natory or other plac			Date		cation - City or T		
	t. Pag tmen tant: ijury		4 ☐ Donation 5 ☐ Othe	r (Specify	)		W. A		1 Cremate					iton, MD		
מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inopartment of Health and Mental Hygiene. In its marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar is ust be notified at once.		21. Signature of Funeral Serv	ice Licen	see/ //	1		$ G^2 $	Name and Address	cren	atic	n Servi	<b>c</b> e	P.O. Bo	x 784	
			23a. Part 1. Enter the disease	or com	plications that	caused t			everly L.					rksvill	Approximate Interval Betw	1029
	No. minimum	K 1	shock, or heart failure. Immediate Cause (Final	List only	one cause on	each line	9.			3,			,	19	Interval Betw Opset and De	een eath
Jan.	hysician /Medical		disease or condition resulting in death)		a. Due lo		conseque	mce of):	1/0						Day	5_
	Examiner				h	(0. 00 0										
	υ . <del></del>	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	J	Due to	(or as a	conseque	nce of):								
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last		c	,										
5	ficate be executed physician and s the burial-transit		rooding in dodiny Edot		Due to	(or as a	conseque	ince oi):								
	ficate phys the	dical			.d											
5	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	ļ	23c. If <u>ye</u> s, ou									23d. Date of deli	very	
į	death e atte d for	icia	in the past 12 months? 1 □Yes 2 No		4 ☐ Pre	gnant at	2 ☐ Fetal of time of dea		Ectopic pregnanc <sub>:</sub>   Other <i>(sp</i> ec <i>ify)</i>	У				Month	Day Ye	ear
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ń	w requires that the dispersion is been signed by the should be detached	by F	Part II. Other significant con	ditions c	ontributing to o	death but	t not result	ing in the ur	nderlying cause give	en in Part	I.	1		se contribute to		
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\ [a	siciar certif	Be	25. Was case referred to med examiner?	lical	Hospital:	14		77/0	Oth			h (Check only o				
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VISIO	nding ath. r: Afte e fun	atio	1 Natural 5 Pe 2 Accident inv	nding estigation		nth, Day,	(Year)	Injury	M 1 🗆	k? Yes 2.□	]No					
<u>&gt;</u>	r Atte er deg rector by th	tific		uld not be termined	28e. Plac	e of Injui	ry - At hom . (Specify)	ne, farm, str	eet, factory, office			28f. Location (S		d Number or Ru	ral Route Numb	er,
5	ital on rs aft al Din led in	Cer			18											
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as	ical	(Check only 2 Med	ifying Ph ical Exar	niner: On the	basis of	examination	rledge, deat on and/or in	h occurred at the til vestigation, in my c	me, date a opinion, de	and place ath occur	, and due to the red at the time,	cause(s) date and	) and manner as I place, and due	stated. to the cause(s)	
	thin 2 the 1 cmplet	Medical	one) 29b. Signature and title of ce	rtifier	and ma	nner stat	red.		29c. Licens	e number			29d. Dat	te signed (Month	n, Day, Year)	
	F 3 F 8		· Colla.	1	ala A	0 1	111	7			9-	7				009
,	2		30. Name and address of per	son who	completed car	use of de	eath (Item	23a) (Type.	Print)	11	1		var	wa. y	20,1	007
(	P) ~~		Alan Roh	rei	MI	13	541	251	7:44s	Fren	of	Frede	VIL	k, M	D2170	01
	Sta	te	31. Date filed (Month, Day, Y		- 4	2	r's Signatu	ire		-						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 1530PM January 28. 2009 Connie Lee Marshall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harkord If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days, Yeer) 7. Age (In yrs. last birthday) 50 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 【XF Maruland Director 09/26/1958 216-72-8758 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 436 Doris Circle 21001 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [V] No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specity: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bowling Alley Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Barbara C. Jewell William Lewis Jewell. Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert B. Marshall, IV (husband) 436 Doris Circle, Aberdeen, Maryland 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 d Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 12/3/2009 Bel Air. Maryland 27. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington Street, Havre de Grace, MD 23a. Part1. Enter the disease, or conglications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 days **Physician** /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnapt 3 Ectopic pregnancy in the past 12 more Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 1 Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 DHO 1 Thipatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 0062765 1/29/2009 Aue HAVre de GRACE, MD H0062765

Registrar DHMH 17 Rev 1/2001

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·UNION

o completed cause of death (Item 23a) (Type, Print)

501

22. Registrar's Signature

5

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4 ·	Physician Medical
	Examiner
	Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

5pw

State Registrar

1-	For State Registrar  Decedent's Name (First, Middle,		-	ertificate of L		, ,	g. No 2009	0 4 0 7 9		
1	Arthur	Lasy	Nocco	olino		Month	24, 2009	5:10 A M		
4a.	Facility Name (If not institution,	,		4b. City, Town, or	Location of Deat		4c. County of Deat			
	157 Winslow P		yrs. last birthday	·	Frederi		Calve	rt hplace <i>(State or Foreign</i>		
5	577-48-0101  ual Residence of Decedent	1,50 M 2 □ F 9,		Months Days	Hours Min.	Oct 3,	Day, Year) Country)			
	a. State 10b. County		c. City, Town or L					10d. Inside City Limits		
	MD Calv	rert 1	Prince I	rederick				1 ☐ Yes 2 No		
100	e. Street and Number  Calvert Pines	II Apt 213		10f. Zip Code <b>206</b> 7	78	10	og. Citizen of What Co	A		
11.	. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:		Specily.	e, etc. nite		
17.	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed)  College (1-4or 5+)	(Giv life.	edent's Usual Occupa re kind of work done d DO NOT use retired,	uring most of wo	rking	16b. Kind of Business/	,		
17	. Father's Name (First, Middle, L	acti		Cab Drive		me (First, Middle, N		ic Transport		
	Lorenzo	.431)	Nocco		Celes		,	Armanni		
	a. Informant's Name/Relationsh	ip (Type. Print)	19b. Mai	ling Address (Street a	nd Number or Ri	ural Route Number,	City or Town, State, 2	Zip Code)		
-	Larry Noccolin			Barnesda l				08096		
20	<ul> <li>a. Method of Disposition</li> <li>1 ☑ Burial 2 ☐ Cremation</li> <li>4 ☐ Donation 5 ☐ Other (Sp</li> </ul>	3 Unemoval nom state		position (Name of ematory or other place Veterans	1 20	b 3	20c. Location - City or Cheltenhan			
21	. Signature of Funeral Service L				s of Facility T 👝	UUS	Home Calv			
Ų.	Gar	y J. Goff	8	125 Southe	ern Mary	land Blvd	l Owings,	MD 20736		
dis res	imediate Cause (Final sease or condition sulting in death)  sequentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	a.  Due to (or as a co	nsequence of):  PCCCC  nsequence of):	n.c.	Cardo	0005(ul	u Dicess	Interval Between Onset and Death		
IF	FEMALE:  tb. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year		
Pa	rt II. Other significant condition		t resulting in the	underlying cause give	n in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2⊿No 3  Pr	the cause of death?		
-   -						24a. Was ar autopsy perform 1  Yes	prior to death?	utopsy findings available completion of cause of 2 ☐ No		
25	. Was case referred to medical examiner?	Linesit-f-		1-		ath (Check only one	9)			
07	1 Yes 2 No		2 ER/Outpatie		4 ☐ Nursing F		nce 6 □Other (Spe	cify)		
27	. Manner of Death   Matural   5   Pending investiga   2   Accident   3   Suicide   6   Could in determine	ot be 28e. Place of injury -	At home, farm, s	Work M 1 □ Y	at ? ′es 2∐No	28d. Describe ho	eet and Number or Ru	ural Route Number,		
	4   Hottlicade	building, etc. (5				City or Town				
29	Oa. Certifier  (Check only one)  Certifying  2 Medical E	Physician: To the best of my Examiner: On the basis of exa and manner stated.	y knowledge, dea imination and/or	ath occurred at the tim investigation, in my of	e, date and place pinion, death occi	e, and due to the ca urred at the time, da	use(s) and manner as ate and place, and due	s stated. e to the cause(s)		
29	b. Signature and title of certified	()		29c. License	number 3/23	29	Od. Date signed (Mont	h, Day, Year)		
	. Name and address of person v		(Item 23a) (Type				*			
	Jonathan D. Lo	wenthal, MD	L10 Hosp	ital Road	Prince	Frederic	k, MD 206	578		
31	Date filed (Month, Day, Year)	Senewa D.	Signature Samuel							

			For State	State of Mary			tment of H ificate of L					0000	01.000	
			Registrar  1. Decedent's Name (First, Middle, Las	st)		00/1/	moute of E	Journ			Reg. No. 3. Time of Death 3. Time of Death			
	Physicia		Charlie Lee New	man						Januar	v 27	, 2009	4:00 A M	
*	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4	4b. City, Town, or	Locatio				County of Death		
2			7500 Greer Drive			$\overline{}$	Fort Was					ince Geo		
	Funeral		5. Social Security Number 6. S	ex 7. Age (In X M 2 ☐ F	n yrs. last birth		If Under 1 Year Months Days	Hours	s Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign	
	Director		226-86-3258 Usual Residence of Decedent		52					Sept 7	, 19	56 Virg	<u> 1112                                 </u>	
	ylanc how		10a. State 10b. County	10	c. City, Town	or Loca	ition					1	10d. Inside City Limits	
	e Ma Ba-fs	Director	MD Prince G	eorge's F	Fort Wa	ashi							1 □Yes 2X No	
	vith th	Dire	10e. Street and Number	O			10f. Zip Code					izen of What Cour	ntry?	
	eath v	Funeral	7500 Greer Drive	12. Was Decedent Ever	rin II S	13 Ws	20744	isnanic (	Origin? (Spe	cify Ves or No	USA	14. Race - Americ	can Indian	
0	fter d	Fun	<ul><li>11. Marital Status</li><li>1X Never Married 2 ☐ Married</li></ul>	Armed Forces? 1 ☐Yes 2X No	11 0.0.		as Decedent of H /es, specify Cuba			Rican, etc.)		Black, White,	etc.	
0000	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show ocal Event her cust be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 L	⊒Yes 2 🗖 No	Speci	ity:			Specify: Amer		
ה ה	72 hc "natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	90.	(Give kir	nt's Usual Occup nd of work done o	durina m	ost of workin	g	16b. Ki	ind of Business/In	dustry	
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and	should be ind Mental marked c	To Be	George Linwood Ne	wman				Ann	ie Mil	dred C	arte	r		
Mary	shou and M is ma	П	19a. Informant's Name/Relationship (	Type. Print)	19b.	Mailing	Address (Street	and Nun	nber or Rura	Route Numb	er, City c	or Town, State, Zip	Code)	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Exar	nysician: To the best of miner: On the basis of ex	amination and									
	the lithin 2 the lomblet	Medical	one) 29b. Signature and title of certifier	and manner stated			29c. License	e numbe	er		29d. Da	te signed (Month,	Dav. Year)	
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	Ja		30. Name and address of person who Sylvester Okonkwo	completed cause of death	(Item 23a) (		rint)							
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 9	32. Redistrar's	Signature									
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			For State Registrar	State of Marylan	•	artment of H rtificate of L			ene eg. No.2 N N Q	01.081
\$p.	Dharainia		1. Decedent's Name (First, Middle, Last)					Date of Deatl     Month	Day Year	3. Time of Death
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1	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of Deat	
			Bay Ridge Health (		In a to the total and a color	Annapol If Under 1 Year	IS If Under 24 Hrs.	9 Date of Birth	Anne Arui	
	Funeral		5. Social Security Number 6. Sex 214-05-1516 1□	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign untry)
-	Director		Usual Residence of Decedent	Λ 90				1/26/191	io Snac	ly Side,MD
	land	Ì	10a. State 10b. County		ty, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	호	MD Anne Arun	idel A	nnapol:	is				1 X Yes 2 ☐ No
	r 28a	ie	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	untry?
	h witl	= G	900 Van Buren S	Street		2	1403		USA	A
	deat	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
9	be filed within 72 hours after death with the Maryland Hygiene.  Hygiene.  do other than "natural" or Items 23a or 28a-f show event, the Medic It Examiner must be notified at		1 X Never Married 2 Married	1 ∐ Yes 2 X No If Yes. Give		1 ☐ Yes 2 💢 No	Specify:			Thite
93	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Dogg	dent's Usual Occup	otion		16b. Kind of Business/	Albert .
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г			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line	/			-	est,	Approximate Interval Between Onset and Death
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ord	w require been si should b		/TTY100	phrilaha	1				es Z No 3 P	TODADIY 4 OHKHOWH
ec C	e law r has be je 2 sh	ble						24a. Was a autops	sy prior to	utopsy findings available completion of cause of
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	ie ie	<u>ö</u>	Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	Zuu. Describe in	ow injury occurred	
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Division	afer Dire	Certification:	4 ☐ Hornicide determined	building, etc. (Spec				City or Tow	n, State)	
	spita lours neral filled			rsician: To the best of my kr						
	e Ho 1 24 h le Fu lletely	Medical	(Check only 2 Medical Exam one)	iner: On the basis of examir and manner stated.	nation and/or i	nvestigation, in my o	opinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
	To the Hospital or Attendi within 24 hours after deafth. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	11		29c. Licens			29d. Date signed (Mon	th, Day, Year)
		D	7	NO.		(1)00	063681		1/26/09	
_	(AC)		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type	, Print)	1	01/05	, ,	
	M		Ajit Kurup MD	900 Van Bu		reet Anna	ipolis,MD	21403		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 2.7 2	32. Registrar's Sign		booked				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 200<sup>'9</sup>aı 24, 12:45 PM Fanchon H. O'Donoghue January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5112 Brookeway Drive Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 22, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1931 Indiana 1 □ M 2 □XF Yrs 577-50-0355 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or items 23a or 28a-f shov rent, I'm Medical Evan, incl. must by notified at 1 ☐ Yes 2 ☐ No Director MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5112 Brookeway Drive 20816 USA Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23.
Iry or other traumatic event, the Medical Exactional and Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Completed by Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arnold Frederick Hinrichs Silva Florence Swanson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Blaine W. O'Donoghue/son 4924 Sentinel Drive #102 Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 01/27/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ZNo Month Day 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lung Cancer 1 Yes 2 No 3 Probably 4 Unknown Cardiomyopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Diabetes 1∐Yes 2.⊠No 1 ☐ Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide

Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760. Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached After this iours after death. neral Director: Ai filled in by the fu 24 hours a

with the Maryland

Saltimore, Maryland 21215-0036

Medical completely within 2 To the 0 State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Da

Joseph A. Ball 16220 Frederick Rd. #213 Gaithersburg, MD 20877 32. Registrar's Signature

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D53317

29c. License number

29d. Date signed (Month, Day, Year)

January 26, 2009

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

character

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) C	of He of He fiter		20a. Method of Di				State 20	b. Place of cemeter	Dispos y, crem	sition (Nar	me of other plac	ce)	1	Date	20c.	Location - City	or To	wn, State	
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Doc	permit. Page Department of Important: If any Injury or once.		21. Signature of	uneral Service	Licepaee	2			22.	Name ar	nd Addre	ss of Facili	ty Mo1	eswor	th-W	illiams	Fι	neral	Home
m	Dep Impe		Ky	an M	. 1	)ergi	'n									Marylan	d	20872	
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P.O.	that til ed by detac	P	Part II. Other sign	nificant conditi	ons contri	buting to d	eath but no	t resulting in	the un	nderlying (	cause giv	en in Part	I.	23e. D	Did tobacc	o use contribu	te to ti	ne cause of dea	ath?
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<u> </u>	rysician: nis certifica director, p	Be	25. Was case ref examiner?			spital:		- 57 - 57 - 57			OA Oth	205		h (Check or		a (T)Out			
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2	ding Phy h. After thi funeral	tion	1 Matural	5 Pendi	ng igation	(Mon	of Injury th, Day Yea	ar) I	njury	м	28c. Injui Woi	rk? ]Yes 2[	]No						
Division	deatl deatl ctor: y the	ertification:	2 Accident 3 Suicide	6 Could	not bo	28e. Place	of Injury - ing, etc. (S	At home, fa	rm, stre	eet, factor						and Number o	r Rura	I Route Numbe	B <i>r</i> ,
. <u>.</u>	after Dira Jin b	erti	4 Homicide	9 001011		build	ing, etc. (S	pecify)						City or	r Town, St	ate)			
	spita nours neral	aiC	29a. Certifier	1 Certifyi	ng Physic	ian: To the	a best of my	knowledge	, death	occurrec	at the til	me, date a	nd place.	and due to	the cause	(s) and manne	er as s	lated.	
	To the Hospital or Attending Physician: The law requires that the death cartificat within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edicai	(Check only one)			and man	iner stated.	mination an	avor inv				ath occur	red at the ti		and place, and			
	To T To T	Σ	29b. Signature ar	nd title of certific	er /	0		N.		29	c. Licens	se number			29d.	Date signed (A	nonth,	uay, Year)	
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	(6)		30. Name and ad	Idress of person	who com	pleted cau	se of death	(Item 23a)	(Type,	Print)		-		0 1	* (		^~	n 216	DAE!
			31. Date filed (M	te J.	Rea	320	Registrar's	Signature	<u>х</u> С		۱۷۱ر	CH	ve	WU	1150	oury,	111	Dais	201
	St Regist	ate rar		AN 27	2009	Den	un	1.	Soa	Med						- 26			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician Thomas Bernard Polito, Sr. January 26, 2009 3:15 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Holy Cross Hospital Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months xx M 2□ F Director 78 579-36-7972 1930 Washington, March 7, DC Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10710 Douglas Avenue 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 No If Yes, Give Year or Dates: 1949- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. by Specify: 1949-51 White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Building Supplies 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Antonio Polito Alice White 2 Department of Health an Important: If them 27 is many injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Alice Ewers/Daughter 10710 Douglas Avenue, Silver Spring, MD 20902 20b. Place of Disposition (Name of cometery, crematory or other place)
Arlington National 20c. Location - City or Town, State 20a. Method of Disposition 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 4, Arlington, Virginia 4 Donation 5 Dother (Specify) Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer vrs /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Acute Myocardial Infarction week that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Chronic Congestive Heart Failure months IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 40 2 No 1 □Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Nomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier parich BM MI D0065485 ra

Registrar

State

Barbara Supanich, MD

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ares

1500 Forest Glen Road, Silver Spring,

MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5:32 February 3, 2009 GEORGE W. PARKER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours Days Months 1 M 2 □ F 81 Maryland 216-20-8407 10/20/1927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Darlington Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21034 3330 Hughes Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. No No HYes, Give Year or Dates:1 945–48 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Repair Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eunice Whitley George Washington Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD3330 Hughes Road, Darlington, 21034 Diane R. Monk/Step-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 2/7/2009 Darlington, MD 22. Name and Address of Facility 21. Signature of Juneral Service Licen Harkins Funeral Home, Inc., Delta, PA 17314 C. Koverx e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) years Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to maneula cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□ No 24a. Was an autopsy 2 No 1□ Yes 26. Place of Death (Check onl one

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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"natural", or items edical Examiner n

traumatic event, the Medical

is marked other than

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra

Hygiene.

filed

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by Funeral

Completed

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death with the Maryland

21215-0036

Baltimore, Maryland

2000

3

February

Washington

George

Division or Vital Records, P.O. Box 68760,

burial-transi and signed by the attending physician d be detached for use as the buria The law requires that the death certificate be been si this certificate has ral director, page 2 or Attending Physician: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral

Physician/Medical

Completed by

To Be

Medical Certification:

25. Was case referred to medical examiner? 2 No 1 Tes 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier (Check only one) Hospital: 1 Impatient 28a. Date of Injury (Month, Day Year)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Rd. Suite 206 Bel Air, MD

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

5 ☐ Pending investigation

6 ☐ Could not be

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arrillo

State Registrar

			1 - For State Registrar	State of M	laryland / De		Health and		iene 009	04086
	Physici		Decedent's Name (First, Middle, I	ast)				2. Date of Deat Month	h Day , Yea	3. Time of Death
	Physici /Medi		JEFFREY		S:	RA.	HT	JANUAY		09 3:15 A M
	Examir		4a. Facility Name (If not institution, g	ive street and number	7)	4b. City, Town	, or Location of De		4c. County of De	ath
			THE JOHNS H	OPKINS	HOSPITAL	BALT	IMOR	E CITY		
	Funeral Director		154-44-9022	Sex 7. A	ige (In yrs. last birthda 58 Yrs.	y) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Dec 13,	<sup>year)</sup> 1950 Nev	irthplace (State or Foreign Country) V Jersey
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	the Maryl	Funeral Director	DC 10e. Street and Number		Washingto	on, D.C.				1 XYes 2 □ No
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Ö	thor.	Completed by	15. Decedent's	1		edent's Usual Occ	unation		16b. Kind of Busines	lite
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au	d be antal	To Be	Robert Donald Ra	*			Lois No		naiosii osinains)	
2	should ind Men marke umaric	۲	19a. Informant's Name/Relationship		10h 14e	ilian Address (Can				-
Maryland	nd 2 salth an 27 ie i		Brendan Rath/son	(Type, Fill)				Rural Route Number, Annapolis		
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	Physician		23a. Part1. Enter the dilease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that cause by one cause on each	ed the death. Do not e	inter the mole of d	ying, such as card	liac of respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	aDue to (or a	s a consequence of):					14 NOURS
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P.O. Box	Physicien: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be detached for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	Ectopic pregnan			23d. Date of d Month	elivery Day Year
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	To To the	Σ	29b. Signature and title of certifier	7 .	1 000	29c. Licer	nse number	29	9d. Date signed (Mor	nth, Day, Year)
	_		Muslean	+ reduces	e Meur	MD D	101710	9 -	TANIMEN	29 2009
(	0)0		30. Name and address of person wh	o completed cause of	death (Item 23a) (Typ	e, Print)	3110		GOO NORTH	WOLFE STREET
6	JW.		CHRISTIAN FREDER	RICKMEYF	RIMD :	JOHNS HI	PKINS H	OSPITAL	BALTEMA	re, md 21287
	Sta Registr		31. Date filed (Month, Day, Year)	2009 32. Regis	trar's Signature	horsel				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04087 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Vear **Physician** 1258 Charles Emerson Robinson 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL MEDICAL 5421364124 HICSMICE TENINSULA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 26, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 ☑ M 2 □ F 88 219-07-7696 Delaware Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director **Ouantico** Wicomico MD the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. USA 21856 22399 Wetipquin Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? July 29 1 ⊠Yes 2 □ No1944— If Yes, Give Year or Dates: Aug. 27,45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Black 2 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Motor Vehicle Administration llth Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Levi Robinson Merelia Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 22399 Wetipquin Road - Quantico, MD 21856 Isenia Robinson/Wife Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 28,09 Quantico, MD Friendship UMC Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Jolley Memorial Chapel, P.A. - 1213 Jersey R - 1213 Jersey Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Due to (or as a cons quence of): disease or condition resulting in death) /Medical Examiner 72046 othericht Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 2**∀** No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No COP 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FER/Outpatient 3 I DOA Other: 2 -Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hor to the Fune completely f

Baltimore, Maryland 21215-0036

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27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury Mo		8d. Describe how injury or	courred			
3 Suicide 6 Could not leadermined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory, office (y)	2	8f. Location (Street and N City or Town, State)	lumber or Rural Route Number,			
	Physician: To the best of my known in the basis of examination and manner stated.							
29b. Signature and title of certifler		29c. Licen	29c. License number 29d. Date signed (Mo					
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30. Name and address of person who	completed cause of death (Iten	n 23a) (Type, Print)	,					
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31. Date filed (Month, Day, Year)	32. Fegistrar's Signa	iture 0						
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State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04088 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EORGE WN. RIFFET Day Year **Physician** 01.15 AM FEBRUARY. 04. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HANFORD MEMORIAL HOSITTAL HAURE de GRACE HARFORD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☑ M 2 ☐ F 71 228-46-7535 Director 10/2/1937 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Director Harford Aberdeen 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 122 Grant Street 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married XX Married 1 ☐ Yes 2 X No Specify: White ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator 8 Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) I and 2 should be fill lealth and Mental H Im 27 Is marked otl Be George Washington Riffey Josephine Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Nancy Riffey/Wife 122 Grant Street, Aberdeen, Department of Health important; if item 27 any injury or other troonce. MD 21001 3altimore, Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ND Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Remeval from State Dublin So. Cemetery 2/7/2009 Darlington, Md 21. Signature of Fune al Service Lice 22. Name and Address of Facility Kober Harkins Funeral Home, Inc., Delta, Pa 17314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JEDTICETTIA **Physician** /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Creer of denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exami Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. CONGESTIVE HEARY FAILURE, PERICULAR EFFLUSION, END 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed STAGE NENAL FAILURE CHIENIC OPSILUCINE 24a. Was an autopsy Were autopsy findings available prior to completion of cause of performed BISGASE, CAR SUCTIONALE death? 1 ☐ Yes PALICINSONS ONGASE 1∐ Yes 2 🗀 No ONAL7 2 No or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation Injury JEDEGE 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours and To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS 21778 FEBRUALT.04.2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARFORD MEMOURE HOSPITAL, HAVRE de CRACE 171 21078 ALAN SWEATHER 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

SK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sweeney 0530 Ruth January 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 19, 9. Birthplace (State or Foreign Funeral Months Days Hours 1 □ M 2 15 F 215-18-0430 88 1920 Huntingtown, MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Director 1 ☐ Yes 2 No Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2197 Hallmark 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify. 2 3 ₩ Widowed 4 Divorced Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Purchasing Agent Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Trott Edith Ward ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2197 Hallmark Drive Gambrills, MD 21054 William Sweeney (son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 26 Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Miranda Cemetery 2009 Huntingtown, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of a ral Service Licensee Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition Dement **Physician** disease or condition resulting in death) moor yrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carry g Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown signed by I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes Division of Vital 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation thin 24 hours after death.

the Funeral Director: A puppletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Within 2 To the

State Registrar (Check only one)

29b. Signature and title of certifier

Mirza Nusairee. MD 1667 Crofton Centre Ste 1 Crofton, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 27 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO0 40579

29d. Date signed (Month, Day, Year)

1-23-09

	1	For State Registrar	State of Maryland	•	tificate o		Re	eg. No.?	09	0409
Physicia	n	1. Decedent's Name (First, Middle, Last) Ethe1		Sto	ogsdill		2. Date of Death Month January	Day	Year 09	3. Time of Deat
/Medica Examine	-	ta. Facility Name (If not institution, give str Regency Park Assis			Gambr:				Arun	
Funeral Director		5. Social Security Number 016-14-7335 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Day			<sup>Year)</sup> 922	Coun	lace (State or For try)
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental High and Mental High art is marked other than "natural", or items 23a or 28a-f show ther traumatic event, if a Medical Examinar must be realfied at	ral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Anne Arun  10e. Street and Number  564 Belmawr Place  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grade  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  Stratis Vaslios El.  19a. Informant's Name/Relationship (Typ  William Stogsdill  20a. Method of Disposition  103 Burial 2 Cremation 3 Re	ndel Mil  2. Was Decedent Ever in U.S. Armed Forces? 1 □Yes, Give Year or Dates:  ation completed) College (1-4or 5+)  Las e. Print)	16a. Deced (Give life. L Home	ille  10f. Zip Code  10f. Zip Code  (Yes, specify C  Yes 2 IV  Hent's Usual Ockind of work do  NOT use ret  maker	21108  of Hispanic Origin? uban, Mexican, Pus lo Specify:  cupation ne during most of w  18. Mother's N  Helen  eet and Number or  Place Mi	(Specify Yes or No- ordo Rican, etc.)  Forking  ame (First, Middle, I  Scopeliti Rural Route Numbe  11ersville	14. Ra Bla Special Special 16b. Kind of E  Own Maiden Surnal LS r, City or Town	What Cour USA  ce - Americ clock, White, of the What Business/Inc Home me)  1. Home 2. 1108	can Indian, etc.  ite dustry
ficate be executed to permit. Pages by physician and p	dical Examiner	4 Donation 5 Other (Specify)  21. Signature of Funcial Secret Licenses  23a. Part 1. Enter the disease, or complic stock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Kno	Do not enforce of):	2 Ridge	dress of Facility Ha	ardesty Fu Annapolis	s, Md 2	Home,	P.A.  Approximate Interval Betwee Onset and Deat
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aing Pnys n. After this funeral dir	Certification: To Be	eyaminer?	lospital: 1   Inpatient 2    28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At he building, etc. (Specify	28b. Time of Injury	of 28c.	Injury at Work? 1 □Yes 2 □No	28d. Describe I	now injury occ	urred	ral Route Number
to the Hospital or Attention within 24 hours after deat To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  29b. Signature and title of certifier	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or i	29c. Li	he time, date and p my opinion, death of cense number	place, and due to the occurred at the time,	cause(s) and date and place 29d. Date sip	e, and due	to the cause(s)
10/Zaz	ate	30. Name and address of person who come address of person who come and address of person who come addres	propleted cause of death (Item    W   W   W   W   W   W   W   W   W	P	action	flul	Uring 1	Kan B.	Mil	und, 21.

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Sade Monica 9:48 P M 20, 2009 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 25,1945 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🕅 F 63 212-44-5407 Germany Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It would all Event in an Item Liftled At Once. 1 ☐ Yes 2 🙀 No Anne Arundel Arnold MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21012 716 Magothy Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💆 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helda Levak John Leppik ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 716 Magothy Road Arnold, MD 21012 Vaino Sade/ husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 23. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 08 crasto **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pelmonory 205trutino oequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Yea Month Day in the past 12 months? 5 ☐ Other (specify) Tyes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No nema 24a. Was an certificate has b irector, page 2 sh autopsy performed? LON Konal director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

veral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one)

To the Hospital De la State

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JAN23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

JAN 28 2009

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0925 M January 2009 Stanley 4b. City, Town, or Location of Death Sandra Mae Velvetta Hyland /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Easton Memorial Hospital Talbot Easton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 ☐ F 212-66-1348 53 11-28-1955 Director Maryland Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location 28a-f shov 1 ☐ Yes 2 No Director Md. Caroline Ridgely 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23950 Holsinger Lane USA 14. Race - American Indian, items 23a 21660 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No 21215-0036 ŏ Specify: ģ 3 Widowed 4 Divorced Black "natural" Completed Department of Health and Mental Hygiene Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Friels Cannery USDA - Inspector 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be <u>Virgina Elizabeth</u> Leroy Isaac Harris,Sr ၉ Little 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stanley/Husband Wayne 23950 Holsinger Ln., Ridgely, Md. 21660 Baltimore, Q 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 01-24-09 Hillsboro, Md. Sandtown Cem. 22. Name and Address of Facility 21 Ignature of Funeral Service Licensee Bennie Smith Funeral Home 0531 UN 426 Dover St., Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Delosis 10d disease or condition resulting in death) /Medical Due to (or as a consequence of): Preumonia **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☑ No this certificate or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certification: To Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death. after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a **To the Funeral L** Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and vile of dertifier 29c. License number 1-20-2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Washington St, Easton. MD 21601 2+3 219 MD 90 32. Degistrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ラキット State Registrar

31. Date filed (Month. Day

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1 - For State of Maryland /		ertment of F		Mental Hy	giene Reg. No	2000	04095
Phys		1. Decedent's Name (First, Middle, Last)  Robert Henry Swann				2. Date of De Month Januar	eath		3. Time of Death 3:30 P M
_	edical niner	4a. Facility Name (If not institution, give street and number) 3410 Cummings Lane		4b. City, Town, or			40	County of Deal	th
Funer Directe		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth a <i>y, Y</i> ea <i>r)</i>	9. Birt	thplace (State or Foreign buntry) Jersey
Maryland a-f show	ctor	Usual Residence of Decedent  10a. State							10d. Inside City Limits 1 □ Yes 2 ☒ No
th with the 23a or 28 ust be not	ral Director	10e. Street and Number 3410 Cummings Lane		10f. Zip Code 20815			10g. Ci USA	tizen of What Co	puntry?
27.215-UU36  Within 72 hours after death with the Maryland jene. Jene. Than "natural", or items 23a or 28a-f show it than "natural", or items 20a or 28a-f show.	by Funeral	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates: 1952-5	1	Vas Decedent of H f Yes, specify Cuba □ □Yes 2∑ No	lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	D-	14. Race - Ame Black, White Specify: Whi	e, etc.
d 21215-0036 filed within 72 hours aff Hygiene. other than "natural", or ent, the Medical Exemi	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 4 College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired ACTOY	ation during most of wo d)	orking	16b. K	and of Business/	Industry
be filed tal Hy dothe event,	Be	17. Father's Name (First, Middle, Last)				me (First, Middle	, Maider		
C W (4 F		19a. Informant's Name/Relationship (Type. Print) Patricia Swann/wife	410	g Address (Street Cummings	Lane Ch	evy Chas	e, N	1D 20815	
<b>Baltimore</b> , permit. Pages 1 ar Department of Hes Important: If Item any Injury or othe		4 □ Donation 5 □ Other (Specify) W. Ar	unde	sition (Name of natory or other place 1 Cremato	ory 01/		0der	ocation - City or nton, MD	
Deparmi Deparmi Impo	ouce	21. Signature of Funeral Service Licensee  21. Signature of Funeral Service Licensee  MO125  23a. Part 1. Enter the disease, or complications that caused the death. Do	G 1 B	Name and Addre Oing Home everly L	ss of facility Cremat Heckro	ion Serv	rice Cl	P.O. B arksvil	ox 784 1e MD 21029 Approximate
Physicia /Medica Examine	al	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cerebrovascular Due to (or as a consequence	r Ac		3,	,			Interval Between Onset and Death
icate be executed physician and the burial-transit	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to for as a consequence consequence.							
BOX 6 sath certifi attending for use as	ian/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death		Ectopic pregnanc Other (specify)	y			23d. Date of del Month	livery Day Year
COTGS, P.O.  w requires that the deliber signed by the should be detached	ed by Phys	The state of the s	in the ur	nderlying cause giv	en in Part I.				the cause of death?
2 a a	- Ι Ω					24a. Was auto perfo 1 🗆 Yes		prior to death?	utopsy findings available completion of cause of
Of Vita Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?		t all pool Oth	0.51	ath (Check only			
Ling Affer fune	ation: To		Time of Injury	28c. Injur Worl	y at	Home 5 Resi		· · ·	cify)
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: T	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location ( City or To	Street ar wn, State	nd Number or Ru e)	ural Route Number,
he Hospi in 24 hou he Funer pletely fii	Medical	29a. Certifier  (Check only one)  1 ■ Certifying Physician: To the best of my knowledge of the basis of examination and manner stated.							
Vith Com	Σ	29b. Signature and title of certifier	M	29c. Licens D2935				ate signed (Monti	n, Day, Year)
13/1/2		30. Name and address of person who completed cause of death (Item 23a George Graves, M.D. 5530 Wisconsin		Print)		hase, MD			',,
	State istrar	31. Date filed (Month, Day, Year)  JAN 2 9 2009  32. Registrar's Signature							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04096 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Month **Physician** 1039 AM Nell Fae Sinclair 2009 Sanyary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 9 1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 🖾 F 220-09-7238 87 Brunswick, MD Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Fairfax Springfield 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 22150 USA 7202 Doncaster Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify. If Yes, Give Year or Dates: Specify: \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Safeway Stores in Elementary/Secondary (0-12) College (1-4or 5+) Cashier McLean, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Thompson Charles Booth ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 7202 Doncaster Street, Springfield, VA Pat Washington, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Park Heights Cemetery 1/28/09 Brunswick, MD 4 □ Donation 5 □ Other (Specify), 21. Sig whyre it in red Semi of Leefsee Barbara A. Williams, Owner 22. Name and Address of Facility
John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hour 9331 Wy aspivo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner en coulde Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ne requires that the death certificate be executed ig physician and as the burial-transit Exami Due to (or as a consequence of): O. Box 68760, Physician/Medical attending g IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) s been signed by the s 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an page 2 certificate | 1 ☐Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural spltal or Attendin nours after death. neral Director: Af y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a, Certifier 1🖄 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28365 ausen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strail Hagestein 1902/140 null 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 27 2000

DHMH 17 Rev 1/2001

Registrar

Jack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician**  $\mathbf{P}^\mathsf{M}$ Stanley Vincent Szapeil January 26, 2009 5:08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 👿 M 2 🗆 F Director 92 30, 1916 New York 075-03-5546 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Exercises, and be putfilled a once. 1 ☐ Yes 2 X No Director Maryland Montgomery Gaitherburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 25101 Seneca View Court 20882 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No
If Yes, Give
Year or Dates:1944-70 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Colone1 Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Vincent Stanley Szapiel Valerya Anna Swarz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20882 Wife Eleanor Katherine Easitus Szapiel 25101 Seneca View Court, Gaithersburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 4☐Donation 5 ☐Other (Specify) Arlington, Virginia Funeral Service Lice u ee 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. F e the disease, br complications that cay indithe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if h art failure. List only one cause on ear h line. Approximate Interval Between Onset and Death Immediate aus (Final disease or condition resulting in de III) **Physician** 2 months Repiratory Failure /Medical Due to (or as a consequence of) Examiner Bilateral Pneumonia 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy perform 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \)Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death. 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosl within 24 ho To the Func and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D45843 January 26, 2009 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Aly, MD,

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

10110 Molecular Drive, Suite 105, Rockville, Maryland 20850

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		Olale 0	i iviai yi			icate of	Death	World II	Reg. N	/11114	04098
			1. Decedent's Name (Fire	it, Middle, La	st)						2. Date of D	eath	Day Year	3. Time of Death
	Physiciar /Medica		Jeanne			<u> </u>	Sa	lins			Janua	ry 2	6, 2009	7:05 A M
	Examine	r	la. Facility Name (If not i				_1_2			or Location of Dea	ath	4	ic. County of Deat	
1			The Hebrew 1  5. Social Security Number				yrs. last birtl		Rockvi Under 1 Year		s. 8. Date of E	Birth	Montgom	ery hplace (State or Foreign
	Funeral Director	- 1	214-14-1087	0.0	I □ M 2 1 F	86			onths Days	Hours Mir		Day, Yea <b>/</b> 192	2 0	untry) MD
P		- 1	Usual Residence of Dece											
arylar	show	- 1		County Ontgom	erv		: City, Town Silver							10d. Inside City Limits 1 X Yes 2 ☐ No
the M	28a-f	Director	10e. Street and Number						Of, Zip Code			10g (	Citizen of What Co	
with	a or	5	15115 Inter	lachen	Drive	#102				906			ited Sta	
death	ms 2	<u> </u>	11. Marital Status		12. Was Deci	edent Ever i	in U.S.	13. Was	Decedent of I	Hispanic Origin?	(Specify Yes or I	<u> </u>	14. Race - Ame	rican Indian,
d 21215-0036 filled within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mazical Examinar must be rediffied at once.	6	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ [		Armed Fo 1 ∐Yes If Yes, Gi Year or D	ve			s, specily Cub Yes 2. Xi\No		ito nicali, etc.)		Specify: Wh	
<b>5-0</b>	natur	етес	15. [ (Specify on	Decedent's E	ducation ade completed)		16a.	Decedent (Give kind	's Usual Occu I of work done	pation during most of w	orking	16b.	Kind of Business/	Industry
<b>121</b> vithin	than.	Completed	Elementary/Secondary		College (	I-4or 5+)							n	
d 2	Hygie		17. Father's Name (First,		")			Cus	comer	Service 18. Mother's Na	кер ame <i>(First, Mid</i> d		Publishi: en Surname)	ng
lan ld be	rked c	0 2	Charles Mo	x1ey						Libby	Montes			
ary Sshow	s mal		19a. Informant's Name/F				I	_					y or Town, State, 2	Zip Code)
<b>∑, ™</b>	m 27 in	-	Fred Gordon										MD 20852	
Baltimore, Maryland	or oth		20a. Method of Disposition 1 🏿 Burial 2 🔲 Cre		Removal from	State			n (Name of ry or other pla		Date		Location - City or	Town, State
it. Pa	rtmer		4 ☐ Donation 5 ☐			J	udean		Garde		29/09	01	ney, MD	
Bal	Depar Impo any ir once.		21. Signature of Euperal			_		Ēdw	ard Sa	gel Fune Fune Rockv	ral Dir	ecti ke R	on Inc ockville	MD 20852
( ) // Ex	nysician Medical xaminer		23a. Part 1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition	(	aDue to	(or as a cor	telro A th	xl † n: (e, k	Pha Cha OSC	Aleta	ac or respiratory	Tev	10ses	Approximate Interval Between Onset and Death
58760, the rifficate be executed	ng physician and as the burial-transit	cal Examiner	Sequentially list conditio if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		C		nsequence o							,
		Medical	IF FEMALE:									-	1	· · · · · · · · · · · · · · · · · · ·
O. Box	e attend	Physician/	23b. Was decedent pregin the past 12 months 1 Yes 2 No. 9 Unknown			birth 2  nant at time	Fetal death		ctopic pregnan ther (specify)	су		-	23d. Date of de Month	livery Day Year
$S$ $\nearrow$ $V$ ords, P.O	signed by the		Part II. Other significant	conditions	contributing to d	eath but no	t resulting in	the unde	rlying cause gi	ven in Part I.	23e. Di	d tobacc	o use contribute to	the cause of death?
Single Single	an sign	ed by					_				_ 1[	Yes	20 No 3 □ P	robably 4 🗌 Unknown
of Vital Record	as t	Completed									24a. W au pe 1 ∐ Ye:	topsy rform <u>ed</u>	? prior to death?	utopsy findings available completion of cause of
/ita	is certificate h director, page	Bec	25. Was case referred to examiner?	medical						26. Place of D	eath (Check onl			
of \	: ##   I	0	1 Yes 2 No				2 ER/Ou	<u> </u>	3 LI UUA				6 ☐ Other (Spe	ecify)
c g	h. After this funeral di	<u></u>	<u> </u>	Pending investigation		of Injury oth, Day, Yea	<i>ar)</i> 285. !	ime of ijury	28c. Inju Wo M 1	uryat ork? ⊒Yes 2 ⊒No	28d. Describ	e how it	njury occurred	
Division of Vita	death ctor: / y the f	fical	0 🗀 0 0 1 1 1 1	Could not I	pe 28e. Place	e of Injury -	At home, far	m, street,	factory, office	163 2 110				ural Route Number,
Div	s after	Certification:	4 Homicide		build	ling, etc. (S	pecity)				City or	Town, Si	are)	
Le Hospital		Medical			miner: On the								e(s) and manner a and place, and du	
To the	withir comp	Z	29b. Signature and title	of certifier (			4		29c. Licer	ise number	A1	29d.	Date signed (Mon	th, Day, Year)
	10		<b>)</b> ()	hen	Som	w	vo.		100	1808	7	J	ANUA	ry 26,2009
			30. Name and address of	+ PA	HTEL, A	10.	612	Type, Prir	non-	MOSE!	20, R	00	eville	M)2085Z
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1825PM **Physician** Donald L. Shortt 2009 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PENINSULA REGIONAL Centu NICONIC SALISBURU If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday 8. Date of Birth **Funeral** Year) Days Min 1 X M 2 □ F 214-46-4594 61 07/25/1947 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 1X Yes 2 □ No Director Maryland Worcester Snow Hill 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21863 USA 8160 Whiton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Maryland 21215-0036 1 □Yes 2 X No Specify: white Specify: ş 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roxie Harmon Frank Shortt ပ္ 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code)
7613 Holt Rd., Parsonsburg, MD 21849 19a. Informant's Name/Relationship, (Type. Print)
Roxie S. Lewis/daughter Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1/28/09 Salisbury Crematory Salisbury, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischanic (arthornipal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ulmorany 115051 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a considence of) Examiner The law requires that the death certificate be executed neumonia attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sh autopsy 2 No 1 □Yes Division of Vital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation e Funeral Director: Affetely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated To the Iv within 24 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar JAN 28 200

31. Date filed (Month, Day, Year)

MIRZA



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAIG

SAlisbury md

Please Type or Print in Black ladelible Ink, of naure All Copies Are Legible.
Amend Item Professor In Black ladelible Ink, of naure All Copies Are Legible.
State of Maryland Department of Health and Mental Hygiene
Amend #25, 27, & 28a-1, per ME 888h and Mental Hygiene
Certificate of Death

Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year 22:25 M Amy Elizabeth Shipley January 04 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buttimore at If Under 14 Hrs. Hours Min. 5. Social Security Number 6. of Baltimore 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Of **Funeral** 1 □ M 2 🗓 F 43 Yrs. Director 210-92-2502 Columbia May 12, 1965 District Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1XYes 2 □ No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Hillside Road 21750 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∏Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 📉 No Specify White þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry J Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dental Assistant Health Services Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be William R. Povish, II ဂ္ Joyce Santee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Beech Avenue Philippi, WV 26416 William R.Povish, II/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State St.Peter's Catholic 01/09/2009 | Hancock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 141 West Main Street 21. Signature of Fineral Service Licensee Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic Brain /Medical Due to (or as a consequence of): Examiner roltallann Motor Vehicle ALL 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ cate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □ Yes 1 ☐ Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 XYes 2 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after decral Director: After Nov. 8, 2008 2103 1 ☐ Yes 2X No MVA investigation 2 XAccident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Local Highway within 24 hours at To the Funeral C completely filled EB I-70 Hagerstown, MD To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ann Mulhin Myslypreti, MD Res-000 Janusury 04 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amar Madhuri Mangalapudi, MD Sinai Hospital of But timore. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15:55P <sup>™</sup> Robert Charles Thyberg January 22 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery County Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Joint Country)
Aug. 23,1928 Minnesota Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F 80 147-14-6587 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm "ledical Evanins" must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21401 2801 Durmont Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tyes 2 No 1950 If Nest, Give 1970 Year or Dates: 1970 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Department of Defense Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Schreiber Clarence Thyberg ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Durmont Court, Annapolis, Maryland Sally Thyberg / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 1/25/09 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21 Signatur of Funeral Service Licens 147 Duke of Gloucester St., Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 years Coronary Artery Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: nse ( 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) Ö 9 D Unknown cate has been signed by page 2 should be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 凝☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 □ Yes X No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? ospital ...
4 hours after dea...
- ral Director: After ty Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titl D51819 January 23,2009 le ed cause of death (Item 23a) (Type, Print) 30. Name and address

State Registrar

JAN 2 7 2009

Matthew J.

31. Date filed (Month, Day, Year)

Malta,

<u>13</u>2

32. Registrar's Signature

Holiday Court, Suite 201, Annapolis, MD

State of Maryland / Department of Health and Mental Hygiene

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	/Medic	a
E	Examin	е

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evarient must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Regist

	1 - State Registrar		C	ertificat	e of L	Death			Reg. No	. ZL	105	9 0410	4
	1. Decedent's Name (First, Middle, Last)							2. Date of De	ath			3. Time of Death	
an	Ruth Isabelle Aurne	er Tabb						Month 1/22	/200		Year	8:30ат м	
al er	4a. Facility Name (If not institution, give str	reet and number)		4b. City,	Town, or	Location	of Death			c. County	of Death	h	
	Spa Creek Center			A	nnap	olis				Ann	e Ar	cundel	
	5. Social Security Number 6. Sex		(In yrs. last birthd	ay) If Under	r I Year Days		24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year	r)	9. Birtl	hplace (State or Foreigr untry)	7
	239-44-1965	v1 2√2 F	95 Yrs	3.	Days	riouis	Willia.	9/8/1	913			Iowa	
	Usual Residence of Decedent		10 O' T									10d. Inside City Limits	
<u>_</u>	10a. State 10b. County  MD Anne Aruno		10c. City, Town or									1 ☐Yes 2X No	
Š		ueı	Annap										
ä	10e. Street and Number			10f. Zip					10g. C	itizen of V		untry?	
<u>a</u>	35 Milkshake Lane					1403				US			_
n n	11. Wanta Status	Mas Decedent Ev Armed Forces?		<ol> <li>Was Deceder</li> <li>If Yes, spe</li> </ol>	dent of Hi cify Cuba	spanic Or n, Mexica	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	0-		e - Amei ck, White	rican Indian, e, etc.	
N F	1 Never Married 2 Married	1 □Yes 2 No If Yes, Give		1 □Yes	2 <b>X</b> No	Specify	:			Specify	<i>/</i> :	White	
Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	160 0	ecedent's Usu		ntion			16h	Kind of Bu	icinese/	ndustry	_
ete	15. Decedent's Educa (Specify only highest grade of	completed)	(G	ive kind of wo fe. DO NOT u	rk done d	uring mos	st of worki	ng	100.1	I CITICO DE	13111033/1	industry	
Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		ales/ B					T	Real	Fet:	ate	
ပို	17. Father's Name (First, Middle, Last)	<b>-</b>		iTCS/ D	JORC		er's Name	(First, Middle				100	П
	Clarence Ray Aurne	r				Ne	ellie	Slayt	on				
은	19a. Informant's Name/Relationship (Type		19b. M	Lailing Address	s (Street a					or Town.	State. Z	Zin Code)	$\dashv$
		Son		old Saw				lford,				,	
	20a. Method of Disposition		20b. Place of Di	isposition (Na	me of	. :	0	Date	20c. I	Location -	City or	Town, State	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Atlanti	crematory or o			1/25/	2009	G14	an Ru	ırni	e, MD	
	21. Signature of Funeral Service Doensee		Atlanti			-			l			e, P.A.	-
	13- 2.Ch			12 Rid	_			napoli				, I.A.	
	23a. Part1. Enter the disease, or complica	ations that caused the	he death. Do not									Approximate	
	shock, or heart failure. List only one Immediate Cause (Final					\		1.				Interval Between Onset and Death	
	disease or condition resulting in death)	D	P	Izahe	INN	, b	-2m	ufer				14:	_
		Due to (or as a	consequence of):									•	
er	Sequentially list conditions, b.	Due to (or as a	consequence of):	:								_	-
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
Xa	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):										$\exists$
ça	L d												
edic													
	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of								23d. Da	te of deli	ivery	
cia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 ☐ Ectopic   5 ☐ Other (s		′				Mo	onth	Day Year	
Completed by Physician	9 □Unknown	9 ☐ Unknown											
ج ح	Part II. Other significant conditions contr	ibuting to death but	not resulting in th	ne underlying o	cause give	n in Part	l.	23e. Did	tobacco	use cont	ribute to	the cause of death?	
다 다								1 🗆	Yes :	2 000	3 Pr	obably 4 Unknown	1
lete								24a. Was		24b.	Were au	topsy findings available	)
Ë								perf	opsy ormed?		death?	completion of cause of	
ပိ	25. Was case referred to medical					26 Plac	e of Death	1 □Yes		10	1 L Yes	2  No	$\dashv$
o Be	evaminer?	spital:	t 2 ER/Outpa	atient 3 🗆 D	OA Othe			me 5 Res		6 □ Oth	ner (Sne	cifu)	
Ë	27. Manner of Death	28a. Date of Injury	28b. Tim	ne of	28c. Injury	/ at		28d. Describe				ony)	$\exists$
ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day,	Year) Inju	Iry M	Work 1 □ \	? Yes 2. [	]No						
ij	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm	, street, factor	y, office			28f. Location	(Street a	and Numb	per or Ru	ıral Route Number,	
ert	4 Homicide	building, etc.	(Specify)					City or To	wn, Sta	ite)			
al C	29a. Certifier Certifying Physic	cian: To the best of	my knowledge, o	death occurred	at the tin	ne, date a	ind place,	and due to th	e cause	(s) and m	anner as	s stated.	
Medical Certification: To	(Check only 2 Medical Examine one)	er: On the basis of and manner state	examination and/eed.	or investigation	n, in my o	pinion, de	ath occur	red at the time	e, date a	nd place,	and due	to the cause(s)	
Me	29b. Signature and title of certifie			29	c. License	number	02/		29d. D	ate signe	d (Month	h, Day, Year)	
1	M 11/4 12	Cun			03	1	US (	0		1/2	3/9	2001	
٢	30. Name and address of person who com	pleted cause of de	ath (Item 23a) (Ty	rpe, Print)	r			۸		1			$\neg$
	Gas I Sar	we a	2/061	19195	who	. n	we	Che	, Les	M.	> 0	2/6/9	
te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1 .	4							~ /	
ar	IAN 2 7 200	141 / 1200	A . M	Mars San									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per Hate of Maryland / Department of Health and Mental Hygien 0 0 9

1 - State Registrar

Certificate of Death Reg. No.

009 04103

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit:

Division of Vital Records, P.O. Box 68760,

To the Hosp within 24 ho within 24 ho completely for the Function of the State Benear American Medical

	1 - State Registrar	Cer	tificate of	Death	Re	2 U U J eg. No.	04100
	1. Decedent's Name (First, Middle, Last)				2. Date of Death	) Day You	3. Time of Death
n il	Francis Joseph Tiernan				1/23	/ 2009	7:30pm M
r	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of De	
	Anne Arundel Medical Center			napolis		Anne Ar	
	XX.	(In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreig Country)
	Usual Residence of Decedent	115.			5/31/19:	30	NY
		10c. City, Town or Loc	ation				10d. Inside City Limits
ò	MD Anne Arundel	West F	River				1 □Yes 25⁄2 No
i i	10e. Street and Number		10f. Zip Code		10	Og. Citizen of What	Country?
<u> </u>	5235 Chalk Point RD.		2	20778		USA	
ner	11 Marital Status 12. Was Decedent Ev	ver in U.S. 13. W		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Ai	merican Indian,
Completed by Funeral Director	1 ☐ Never Married	1948-	Yes ≱(¬No	Specify:	nican, etc.)	Black, Wi	
5	3 Widowed 4 Divorced Year or Dates:	1951	□ ies ⊅(Xivo	эреспу.		Specify:	White
ete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give k	ent's Usual Occup	oation during most of work d)	ing	16b. Kind of Busines	ss/Industry
ᆵ	Elementary/Secondary (0-12) College (1-4or 5+)		_	d)		M	1
ဒ	17. Father's Name (First, Middle, Last)	Capt	aln	18. Mother's Name	CEiret Middle N		shington PD
ä	Frank Tiernan				Nichols	•	
<u>°</u>	19a. Informant's Name/Relationship (Type. Print)	10h Mailin	a Address (Street	and Number or Run			Zin Codo)
	Mary Tiernan Wife		-			ver, MD 2	
	20a. Method of Disposition 1	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	ce)	Date 2	20c. Location - City	or Town, State
	4 □ Donation 5 □ Other (Specify)	Ore Lady				West Rive	
	21. Signature of Funeral Service Licensee	22.	. Name and Addre	ess of FacilityHard	lesty Fur	neral Hom	e, P.A.
	1.9		Ridgely			, MD 2140	1
	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do not ente	er the mode of dying	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	2diugas	Ja SV	16de			CON C
	Due to (or as a	consequence of	. 1	1 1/00	1		
_	Sequentially list conditions, b. Due to (exceed)	consequence of):	es tuil	Bue	9		dey
u u	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence or).					
xar	that initiated events	consequence of):					+ /
ä							
Medical Examine	U-						
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome o 1 ☐ Live birth 2	f pregnancy	Ectopic pregnanc			23d. Date of	delivery
sician/	1 Yes 2 No 4 Pregnant at t		Other (specify)	-y 		Month	Day Year
Š	9 Unknown						
Completed by Phy	Part II. Other significant conditions contributing to death but	not resulting in the un	iderlying cause giv				to the cause of death?
ted	11 700 977 P1 954	16 >)	navau		1 🗆 Ye	s 2 No 3	Probably 4 Unknown
De le					24a. Was ar autops	v l prior	autopsy findings available to completion of cause of
5					perform 1 □Yes 2	ned2 death 1111 No 1 □ Y	
Ř	25. Was case referred to medical examiner?		104	26. Place of Deat	h (Check only one	9)	
<u> </u>	1 Yes 2 No rospital 1 npatien 27. Manneyof Death 28a. Date of Injury	t 2 ER/Outpatien		4 LI Nursing Ho		nce 6 Other (S	(pecify)
ion	1 ☐ Matural 5 ☐ Pending (Month, Day,	Year) Zeb. Title of Injury	Wor	ryai rk? ]Yes 2 □No	28d. Describe no	w injury occurred	
lical	3 Suicide 6 Could not be	y - At home, farm, stre		1163 2 1140	28f Location (St.	reet and Number or	Rural Route Number,
erti	4 Homicide determined building, etc.	(Specify)	, , , , , , , , , , , , , , , , , , ,		City or Town	, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u>ة</u>	29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death	occurred at the t	ime, date and place,	, and due to the c	ause(s) and manne	r as stated.
Medical Certification: 10	(Check only 2 Medical Examiner) On the basis of and manner state	examination and/or in\	vestigation, in my	opinion, death occur	red at the time, da	ate and place, and o	due to the cause(s)
ž	29b. Signature and title of certifier		29c. Licens	se number	911	9d. Date signed (Mo	onth, Day, Year)
)	N M M		171	n5) 7	17	1/04/10	00 )
	30. Name and address of person who completed cause of dea	ath (Item 23a) (Type.)	Print)	Anu	del 1	hadica	Conten
е	31. Date filed (Month, Day, Year) 32. Registrar	's Signature		V			
r	JAN 2 7 2009 Senser	2 B. Ja	ares				

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** URK 1545 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7/22/1918 9. Birthplace (State or Foreign **Funeral** 1□M 22 F Months Days Hours Min. WVA 215-40-8137 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Medical Exercity or item by perting at once." 10h County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 3√√No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 USA 1429 Winnie Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify. 2 Specify: 3 ➡Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maybell Buckland Jessie Joe Adkins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Turke 4240 Carvel Lane Edgewater, MD 21037 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖟 🕏 urial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 1/23/2009 Davidsonville, MD Lakemont Cemetery 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician NO 960 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗓 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation within 24 hours aner control to the Funeral Director; Aff 2 Accident 1 ☐ Yes 2 No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifief EY ENSE HIGHWAY ANNARYMINER death (Item 23a) (Type, Print) WY

State Registrar

31. Date filed (Month, Day, Year)

32/Registrar's Signature

JAN 23 2009

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar	(5)			Ce	rtificate of	Death	)		leg. No2	00	19	04105
Physi	cian	1. Decedent's Na			•					2. Date of Dea	Day	20	Year	3. Time of Death 4:10AM M
/Med Exam				THOMPSON on, give street and			4b. City, Town,	or Location	of Death	JANUAR'			of Death	4:10AH
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Funera		5. Social Security		6. Sex 1 □ M 2 <b>X</b> F		s. last birthday) Yrs.	If Under 1 Yea Months Days		r 24 Hrs. Min.	8. Date of Birti (Month, Day	, Year)	- 1	Coun	
Directo	r	056-03- Usual Residence			94	113.				JUL 10	, 191	14	NEW	YORK
72 hours after death with the Maryland natural", or items 23a or 28a-f show the Examiner must be notified at	_	10a. State	10b. County		10c. 0	City, Town or Lo				_			1	0d. Inside City Limits
he Ma 8a-f s	Director	MD	TAL	ROT		B.E	ASTON							1X Yes 2 No
with t	ğ	10e. Street and f		DD CHTS	m= 211		10f. Zip Code	21601			10g. Citize	en of wi	USA	•
death ms 23	Funeral	11. Marital Status	YNWOOD ]	12 Mac D	ecedent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cu		rigin? (Spe	cify Yes or No-	14		- Americ	an Indian,
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and 2 sho salth and n 27 is ma				/DAUGHTEI	R	1	O EDGEM						. ,	Coae)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1829 **Physician** 23 2009 JANUARY JOYCE W. TAYLOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Easton 1A 1BOT The Memo

5. Social Security Number HOSDI Memoreni Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 82 JUL 15, 1926 MARYLAND 218-20-8210 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Merkal Hyglend. Insportant: It item 72 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mexical Examinat must be notified at any Injury or other traumatic event, I'm Mexical Examinat must be notified at 1 ☐ Yes 2 ▼ No Director MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8841 UNIONVILLE ROAD 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 km No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: WHITE ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTING VICE PRESIDENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES B. WALLS MARY HELEN HUBBARD ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8841 UNIONVILLE ROAD, EASTON, MARYLAND 21601 NORRIS E. TAYLOR/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/30/2009 EASTON, MARYLAND SPRING HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA GROWSK. M. 200 S. HARRISON ST EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENCEPHALOPATHY Immediate Cause (Final ANOXIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): HEMORILAGE SUBARACHNOID Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a detached f P.O. 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. the

12

31. Date filed (Month, Day, Year)

Mulhetser

30. Name and address / f person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

JOHN BOTSIS M.D. 219 S. WASHINGTON ST EASTON, MD 21601

State Registrar

29c. License number

200999487

29d. Date signed (Month, Day, Year)

1-24-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** 7:30 PM av1 2009 Jam V Arvi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner todla Easton William If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Months MAR 27 1927 81 PA 091-22-9830 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director TALBOT EASTON MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21601 USA 28380 CANVASBACK LANE items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 6 1 ☐ Yes 2 XNo Specify: WHITE ð 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 EDITOR/WRITER JOURNALISM 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BEATRICE BARRINGTON ERNEST L. TAYLOR ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau 28380 CANVASBACK LANE, EASTON, MD 21601 MELISSA I. TAYLOR/WIFE 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION CTR 1/19/2009 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 2/ Joseph 200 S. HARRISON ST EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tollure months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dementia WESTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of; Examiner burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: f yes, outcome of pregnancy
□ Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by emoral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed recurrent 1 □Yes 2 ☑No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760. Division of Vital Records,

death

Pages 1 and 2 should be filed within 72 hours after

Saltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the content of the cont

5+VA

Elliott, MD 31. Date filed (Month, Day, Year) State

JAN 2 0 2009

29a, Certifier

(Check only one)

29b. Signature and title of certified

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton Family

and manner stated

Physicians

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

100059939

508 Idlewid

29d. Date signed (Month, Day, Year)

18, 2009

21401

YOSTON, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28,2009 Month **Physician** Malisa Taylor 9:10A M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince Georges Southern Maryland Hospital ocial Security Number 6. Sex 7. Age (In yrs. las) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 21, 1937 Birthplace (State or Foreign Country)
 Alabama 5. Social Security Number **Funeral** 1 □ M 2 🔀 F 416-56-9868 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, Ite Modical Examinar must be notified at any injury or other traumatic event, Ite Modical Examinar must be notified at any once. 1 ☐ Yes X No Director Faunsdale Hale Alabama 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with U.S.A. 36738 5963 County Road 26 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: Black \$ 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elnora Hunter Natahiel Coleman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5963 County Road 26, Faunsdale, Alabama 36738 Letitia Taylor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Faunsdale, Alabama 2-7-09 Griers Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A. michael 6009 Harford Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Candisvanular ATTRICOCHERSTIC 24 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Disc to for as a consequence of: Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MicHAEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

parket

29c. License number 145365

Sidakoulino. 1170/11ving/tan Rd # bl Fort Coppington M 20184

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiere | 1 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 25, 2009 0630 M Tart Ethe1 W. Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunbridge Nursing Home E1kton Cecil tf Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 📆 F 89 Director 202-01-3087 Oct.3,1919 Holmes, PA Usual Residence of Decedent 10c. City, Town or Location 10a State 10b Count 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or itema 23a or 28a-1 show or other traumatic event, the Medical Experiment must be notified at MD Ceci1 E1kton 1 ☐ Yes 2 XNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Price Drive 23413 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 図 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. white þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than any injury or other traumatic avant. College (1-4or 5+) Elementary/Secondary (0-12) DuPont Co. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William R. Wallew Ethel Rudolph ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1 Heron Court Michael Phillips (friend) Newark, DE 19702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lawn Croft Cemetery Feb.3,2009 Linwood, PA 22. Name and Address of Facility McCrery Funeral Homes, Inc. 21. Signature of Funeral Service Licensee N100746 3924 Concord Pike Wilmington, DE 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CORONARY

Due to (or as a consequence of): ARTERT /Medical **Examiner** FIBRILLADON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit death certificate be executed HYPERTENSION Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No detached for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown leted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Compl After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Hospital or Attending 24 hours after death. 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours as To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V Naya D0065733 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mb 21921 smeet FILKINN 111611 RAS PULA 126 A NARATANA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** White 2009 January 3:45 AM Barbara Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Center  ${ t Clinton}$ 9. Birthplace (State or Foreign Country) North Carolina 8. Date of Birth (Month, Day, Year) 04-04-1934 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Hours Months Days Min. 1 □ M 2 🕅 F 74 Director 216-30-4423 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Mudical Exercitive roust be notified at Director 1 ☐ Yes 2 ☑ No MD Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20657 1260 Coster Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ♥ Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) 10 College (1-4or 5+) food service delicatessen manager . Pages 1 and 2 should be filed w fment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jones Etta Belle Hardison ပ Jesse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Bourne Road, Owings, MD 20736 Brenda J. Lavato, daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. All Saints Cemetery | 01-24-2009 | Sunderland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final alherseles Diseas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed eo Rs and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate 1 ☐ Yes 2.☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature ay 29c. License number 29d. Date signed (Month, Day, Year) 201 on who empleted cause of death (Item 23a) (Type, Print) Name and address of 8 32. Registrer Signature Year) State

DHMH 17 Rev 1/2001

Registrar

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			For	State of Ma	arylan		epartment of			1ental Hy	gien	е	
			State Registrar				Certificate o	Deat	h		Reg. No	.2009	04111
	Physicia	an	1. Decedent's Name (First, Middle							2. Date of De Month	Da		3. Time of Death
	/Medic		Charles A.  4a. Facility Name (If not institution	lbert Wri	gnt		4b. City, Town	or Locatio	on of Death	01	23	c. County of Death	8:35A M
	Examin	er	Chester Rive		1				town		"	Kent	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs.		Months Day		ler 24 Hrs. s Min.	8. Date of Bi (Month, Da	av. Year	9. Birth	place (State or Foreign
aleji e	Director		220-26-3873	1 <b>X</b> M 2□F	84	Yr	s.	110011		08-2	28-1	924 Mai	rýland
	fand ow tt		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town o	or Location						10d. Inside City Limits
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	th the	Jirec	10e. Street and Number				10f. Zip Code				10g. C	itizen of What Cou	ntry?
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	items	Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marri	12. Was Decedent Armed Forces?		.S.	13. Was Decedent of If Yes, specify Co	Hispanic ( uban, Mexi	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)	0-	<ol> <li>Race - Ameri Black, White,</li> </ol>	
5	urs aff	by	3 Widowed 4 Divorced	ed 1 X Yes 2 1 If Yes, Give Year or Dates:	•		1 ☐ Yes 2 N	o Speci	ify:			Specify: B]	lack
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show with the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes	's Education		16a. D	ecedent's Usual Occ	upation	anst of work	ina	16b. I	Kind of Business/Ir	ndustry
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au	lid be i lental i rked o	To Be	Ernest	Wright					Anna	0.		ilson	
Maryland	shound N	F	19a. Informant's Name/Relationsh			19b. N	Mailing Address (Stre						p Code)
	es 1 and 2 of Health a f item 27 Is r other trai		Gladys Hynso	on / Daugh	ter	10	390 Bunt	ing	Rd.,	Cheste	erto	wn,Md.2	21620
ore	jes 1 of He if iten		20a. Method of Disposition  1 ■ Bunal 2 □ Cremation	3 ☐ Removal from State	20b. F	Place of E cemetery,	Disposition (Name of crematory or other p	(ace)		Date	20c. L	ocation - City or T	own, State
Baltimore,	t. Pag tment tant: jury o		4 Donation 5 D Other (Sp	pecify)		ème	crematory or other p Neck Hal tery						Maryland
g	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of Funeral Service	Licensee			22. Name and Add		Be.				al Home
r	1000		23a. Patt1. Enter the disease, or shock, or heart failure. List	complications that caused	I the death	h. Do no	t enter the mode of d	ying, such	as cardiac	tertow or respiratory a	7 <b>n ,</b> M arrest,	aryland	Approximate
	Physician		Immediate Cause (Final	<	ne. 5/5								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as		uence of	):						124495
	Examiner		Sequentially list conditions,	b									
	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of	):						
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68/6U,	eath certificate be executed attending physician and for use as the burial-transit	_		Cd									
	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	Physician/Medica	IF FEMALE:										
X R R	ath ce ttendii or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Feta	l death	3 □Ectopic pregna					23d. Date of deliv Month	rery Day Year
<u>-</u>	he dea the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	time of d	eath	5 ☐ Other (specify)					THO I I	Day
7	that the ded by detac		Part II. Other significant condition	ns contributing to death b	ut not resi	ulting in t	he underlying cause	jiven in Pa	ırt I.	23e. Did	tobacco	use contribute to t	the cause of death?
ra S	w requires that the de been signed by the should be detached	d by	Chronic len	a 1 Failure						10	Yes 2	No 3□ Pro	bably 4 □Unknown
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S	tal or A s after al Direc ed in by	Certification:	4 Dirinicide	building, et	c. (Specii	<i>y)</i>				City or To	wn, Sta	ie)	
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by		(Check only 2 Medical	g Physician: To the best Examiner: On the basis o	f examina	wledge, ition and/	death occurred at the or investigation, in m	time, date y opinion, d	e and place, death occur	and due to the red at the time	cause( , date ar	s) and manner as and place, and due	stated. to the cause(s)
	the ithin 2 the or the	Medical	one) 29b. Signature and title of certifier	and manner st	ated.		29c. Lice	nse numbe	er		29d. Da	ate signed (Month,	Dav. Year)
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	75		30. Name and address of person	who completed cause of c	eath (Item	n 23a) (T	ype, Print)			2 1	(	26/09 Md Z	
	3+VA		Susink. R	USS MO 5	5/6	100	hing to	170	re C	les for	ton	Md 2	1620
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Hospital or Attending Physician: 24 hours a e Funeral I the To the

125 10+VA

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and My

29a. Certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTERDING MD

1 Acritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

BLOOM ING DAVE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 404 AM E AYERS CHARLES PEBRUARY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COLUMBIA COUNTY GENERAL HOSPITAL 8. Date of Birth (Month Day Year) SEP 5 1958 If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 50 Maryland 216-74-4083 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Elkridge Director MD Howard 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 21075 USA 6711 Deer Run Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces?

↑★★ Yes 2 → No
If Yes, Give Year or Dates: 74-78 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Glazier Commercial Glass 12 should be filed w. th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Canter Charles Wesley Ayers Eleanor Jane ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any Injury or other traunonce. 6711 Deer Run Parkway, Elkridge, MD Sharon Lynn Ayers - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 02/12/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensen. Williams <sup>22</sup>MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 56 PS/J HOUN /Medical Due to (or as a consequence of): Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit MELLINS UNKEY DIABERS that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' l Tes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural Certification: 28b. Time of 28d. Describe how injury occurred After Division the Hospital or Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State Registrar PANYENT PANY

29c. License number

D63242

29d. Date signed (Month, Day, Year)

8, 2009

and manner stated.

UTTLE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FFR 1 2 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month HARLES **Physician** 0827AM ARMWOOD 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CNTR BACTIMORE ILAND MEDICAL 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 92 Months Days Hours Min. ir Viano 12 M 2□ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Evaniner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Baltimore Yes 2 □ No **Funeral Director** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First Middle, Last) Be 100 ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUTHUR Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTRODUTESTIDIAL **Physician** MER /Medical Due to (or es a consequence of): Examiner IRCHOSIS Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) led by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 □Yes 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical cause(s)

Division of Vital Records, P.O. Box 68760,  $otin{\mathcal{R}}
otin$ within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i within 2 To the

2	(Check only 2 Medicel Examiner: 0	On the basis of examination and/or and manner stated.			
É	29b. Signature and title of certifier		29c. License num		29d. Date signed (Month, Day,
	Maire Sto	MD	AU41764.	35E18956	02/06/2009
	30. Name and address of person who complete	led cause of death (Item 23a) (Type			
	Charisse Estess	22 S.	GREENE ST	BALTTIMULE	MD 21201
H	31. Date filed (Month, Day, Year)	32. Begistrar's Signature	1		
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Year)

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 06:50 PM 2009 FEB /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AGMES HOSPI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 213-20-576 1 M 2 anlino Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner roust be notified at Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ items 23a maa Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 72 hours after 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NQT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) ouse 24 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daughter Department of Health ar Important: If item 27 is any Injury or other trau Pilo 5024 Balto, Nat Denise M. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-09 Arb utus 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signatura of Furieral Service License 21229 FIH Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ineumonic HSDY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and stransit the burial-transit Box 68760,€ Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) P.O. ed by the a 1 Tyes 2 No 9 Unknown been signed be hould be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an tificate has autopsy page 1 ☐Yes 2 ☐No e Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Injury at Work? 1. Natural 5 Pending investigation al or Attendir s after death. I Director: Af 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of garti 2009 MI 10

Registrar

State

30. the and address of per or

31. Date fled (Month, Day, Year,

Servit Agres Hopital 900 Caton Are.

Bathmere MD 21229

who completed cause of death (Item 23a) (Type, Print)

Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 8135 PM 4a. Facility Name (If not institution, give street and number) 08 02 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore VA Medical Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Months Days 1 X M 2 □ F 216-18-7028 89 June 16,1919 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examinar must be notified at XXYes 2 □ No Director Maryland None Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 3900 North Charles Street USA Funeral Was Decedent Ever in U.S. Armoed Forces? 1/DYes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No White Specify. Specify. þ 3 ☐ Widowed 4 💆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Career Military U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carroll R. Blaney Minnie Louise Litzinger ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Elizabeth Novak DTR 1350 Cedarcroft Road Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition XX Burial 2 Cremation 3 Removal from State Department or Important: If any Injury or Arlington National Cemetery Feb 23,2009 4 Donation 5 ☐ Other (Specify) Arlington, Virginia nature of Funeral Service License 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ZNo 1 ☐ Yes 2 🔼 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier William Holliem, mo 8/2069 8854 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nghien MA (10 N. Greene St.

DHMH 17 Rev 1/2001

State Registrar 31. Date ffled (Month, Day, Year) FEB 1 2 2009 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marylano Oseparthen 6888 ealth 2/09 Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Beath 4a. Facility Name (If not institution **Examiner** 4b. City, Town, or Location of Death Baltimore mo If Under 1 Year | If Under 24 Hrs. | 8 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F Yrs. Director VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore n/a 2222 Be Completed by Funeral Director MD 1XYes 2 ☐ No 10e. Street and Number 2222 E. 10g. Citizen of What Country? 10f. Zip Code 21213 Oliver St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Bar maid Bar 17. Father's Name (First, Middle, Last)
Arthur Glaspie 18. Mother's Name (First, Middle, Majden Surname) Beatrice Jeffries 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie B. Buise (daughter) 2222 E. Oliver St. Balto Md.

a. Method of Disposition

1 Burial 2 Micromation 3 Bernoval from State of Commetery, crematory or other place)

20b. Place of Disposition (Name of Commetery, crematory or other place)

20c. Location - 20c. Locati 21213 20a. Method of Disposition 20c. Location - City or Town, State 2009 Balto. Md. Green Mount Crematory of other place) Feb. 11, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Juner (Specify) <sup>22. Name and Address of Facility</sup> Calvin B. Scruggs Funeral Home Preston St. Balto, Md. Ε. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: မှ 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiel cal

Examiner The law requires that the death certificate be executed burial-transit Box 68760, as the detached for Division of Vital Records, P.O. the ģ page 2 certificate or Attending Physician: this ieral Director: After filled in by the funera To the Hospital within 24 hours To the Funeral

death with the Maryland

, or Items 23a or 28a-f show andrer: wat be nutified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, Item Mical Execut

Baltimore, Maryland 21215-0036

PANICAT KHETERVAL State Registrar

DHMH 17 Rev 1/2001

Medic

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26

29b. Signature and title of certifier

32. Registrar's Signature

(RON

29c. License number D0060520

G GRT4

COCKEYSVILE:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month 2205 PM Physician Barbara 2009 ebruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number Hours **Funeral** Months 1 - M 2 XF 220.36.635 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b Count 28a-f show Examiner must be notified at 1XYes 2 □ No Baltimore Director MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 0 West Northern Pkwy, Apt. 410 21215 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eve Armed Forces? 1 Yes 2 No Race - American Indian Black, White, etc. items ? 11. Marital Status 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates: Specify: Black þ 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOI use retired)

Quality Control Inspecto Completed 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) continental College (1-4 or 5+) ary/Secondary (0-12) Mental Hygiene. arked other than Can Company Inspector 18. Mother's Name (First, Middle, Maiden Surname) event, 1 17. Father's Name (First, Middle, Last) Be marked Bernice ပ other traumatic permit. Pages 1 and 2 shoul Department of Health and MM Important: If item 27 Is marl any injury or other traumationce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (4) tvenue Baltimore MD 21215 Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Woodlawn, MD 0214/09 Woodlawn Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee aughor C. Greene Funeral SKO Randallstown MD21133 8728 Libert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acidosis actic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 2 Fetal death Ectopic pregnancy Live birth Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 2 XNo Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 X No 6 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Director; After to d in by the funer 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Res coo 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 BABADE MOSUNMOLA

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32.

Pigistrar's Signature

09-01157 Joseph Cosgrove Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 04119

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The d	8	Phy	Part II. Other sig	nificant con	ditions o	ontributing	to death but not	resulting in th	ne underlyii	ng cause (	given in F	art I.				e to the cause of death?	
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<b>Re</b> The	, pag	Ö								26 Place	e of Deati	(Check	only one)	03 2			-
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f V Phys	ral di	유	1 ✓ Yes 27. Manner of De	2 No		28a. Dat	e of Injury	28b. Time		28c. Inju	iry at Wo	rk?	28d. Descr	ribe how inj	ury occurred		_
n of adding Ph	e fune	ë	1 Natural		ending		th, Day,Year)	F4 /	:15 pr	1 🗆	Yes 2 🗓	No	subje	ct ha	nged s	elf	
Sio Atter r deat	by th	icat	2 Accident		vestigation	28e. Pla	2/8/09_ ace of Injury - At	home, farm, s	street, facto	ry, office I	building,	etc.	28f. Locati	on (Street	nd Number of	or Rural Route Number, City alena Rd.	.y
Division of Vital Records, tal or Attending Physician: The law requir is after death.	ed in	ertification:	3 X Suicide	de	ould not be etermined	(Specify	house						Mill	ingto	n, MD	alena ku.	
Divisior To the Hospital or Attend within 24 hours after death To the Finneral Director:	completely filled in by the	O	29a Certifier	0 416.1-	Physician	To the h	act of my knowle	dge, death o	ccurred at t	he time, d	late and p	olace, and	due to the	cause(s) ar	nd manner as	stated.	
the I hin 2	nplete	Medical	(Check only one) 2	/ Medical E	xaminer: 0	on the basis	s of examination	and/or inves	tigation, in	my opinior	n, death d	occurred a	at the time, o	date and pla	ace, and due	to the cause(s)	
To Wit	100	Me	29b. Signature a	nd title of cer		TA HIGHING	State d.		2	9c. Licen:	se numbe	er				(Month, Day, Year)	
			Parles	1658n	who	11 m	B			O.C.	M.E.			Feb	oruary 9, 2	2009	
			30. Name and ac	dress of per	son who co	mpleted ca	use of death (Ite	m 23a)									
			Pamela E			Assistan	t Medical Ex	aminer		n Stree	et, Balti	more, I	MD 2120	1			
•		ate	31. Date filed (M	onth, Day,Ye	ar)	3	Registrar's Signa	attre	ales								

State of Maryland / Department of Health and Mental Hygiene Reg. N.2009 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** Dardell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rehabil tation Extended Care N/A altimore f Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min 1**√** M 2□ F Months Days Hours Maryland Director Oct 29, 1929 215-28-5879 79 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō U.S.A. 21223 2 North Smallwood Street ite⊞s 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 5 1951 1 ☐Yes 2 No Specify: þ Black 3 ₩ Widowed 4 □ Divorced "natural", 1953 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Maone. Elementary/Secondary (0-12) College (1-4or 5+) Private Employer Skill Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Beatrice Cook** Fred Cook 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 504 Roundview Road Baltimore, Maryland 21225 Sylvia White 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. 02/17/09 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 22. Name and Address of Facility 21. Signature Funeral Sen Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician + de-40 Carenoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No performed? (es 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6.38PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

KNOWN

Year

X Yes 2 No

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

00 Lock Rayey Boulevard, Baltimore, Maryland 21219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year LESTER CARSON 2009 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. 2200 Prince Avenue Suit | and If Under 1 Year | If Under 24 Hrs. ter 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Min. Director 239-38-4439 83 DEC. 30, 1925 NC Usual Residence of Decedent filed within 72 hours after death with the Maryland ns 23a or 28a-f show must be notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No PRINCE GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2200 PORTER AVENUE 20746 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 ⊠Yes 2 □ No 6/1945
If Yes, Give
Year or Dates: 3/1946 er than "natural", or Items The Medical Experiment Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by 3 Widowed 4 Divorced Specify. 3/1946 BLACK 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTO BODY TECHNICIAN SELF-EMPLOYED permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If item 27 Is marked other any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY CARSON LENOR COWAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET M. CARSON / WIFE 2200 PORTER AVENUE SUITLAND, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 02-13-2009 SUITLAND, MD 22. Name and Address of Facility MARSHALL 'S FUNERAL HOME OF MD 21. Signature of Fune a Service Licensee once. DONALD R. GRAY SUITLAND, MD 4308 SUITLAND ROAD 20746 Enter the disease, or heart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 21 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. ed by the a 1 □Yes 2 No 9 Unknown 9 Unknown signed by 1 I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) JEYes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54 300/ 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 200 /Medical Facility Name (If not institution, give street and number) Gity, Town, or Location of Death 4c. County of Death Examiner Randallstown thucs CA 7 Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Year) **Funeral** Months 1 M 2 □ F -4229 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State items 23a or 28a-f shoviner must be notified at 1 Yes 2 No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1SA 14. Race - American Indian, Completed by Funeral Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. "natural", or iten 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married 1□Yes 2□No Baltimore, Maryland 21215-0036 Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William 1111an 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 Milloond Ct. Uwing

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest 2/17/09

22 Name and Address of Facility Owings Mills, MD Z1117 permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Niece Terry Wedlock
20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Owinas Mills, Mb 4 □ Donation 5 □ Other (Specify) c Greene funeral sus 21. Signature of Funeral Service Licensee 23a. Part1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diova SPUSE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760. nding physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 🗌 Yes 2 No 3 ☐ Probably peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform has 2 **Z** No 1☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 DER/Outpatient 3 DOA 1 | Inpatient ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Injury 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 Tyes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature-and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) -01 Year) 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#29c, perDVR, G888, 2712/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 12:52 PM Dixon Lobin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Carter MD Jerry Medicul If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, ID 3.5) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗖 F 0644085 Director Usual Residence of Decedent 10d. Inside City Limits 10b, County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Evandration that he notified at 1 Yes 2 □ No BAltimorE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò death with USA north Hilton 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ð 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumests. Elementary/Secondary (0-12) College (1-4or 5+) Ertifile nurs. ha nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 4011 hom ပ 19a. Informant's Name/Relationship (Type. Print) PAV& H+E 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUE BALLE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2-14-09 BAlto CAIMEI CEM 22. Name and Address of Facility Ph. 11. PA WEATHE 21. Signature of Eureral Service Licensee OlIVERST BAITO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Intracrunial hemorrhad disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) P.O. the detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an has autopsy /performed? Yes 2 \Bo certificate sant's 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D67708 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) 32. Registrar's Signature State 2 2009 Registrar

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	-	For State Registrar	ate of Mary		epartment of F Certificate of I			giene <sub>Reg. No.</sub> 2	9 04124
		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
Physicia /Medic		HANNAH			ENĢEL		FEBRUA	RY 8 2009	8:30 P M
Examin	er	4a. Facility Name (If not institution, give stree		1 -		r Location of Death		4c. County of Dear	th
Funeral		7218 PARK HEIGHTS  5. Social Security Number 6. Sex	7 Age (In	15 yrs. last birth	day) If Under 1 Year	I MORE  If Under 24 Hrs.	8. Date of Birt	N/A th 9. Bir	thplace (State or Foreign
Director		213-03-6899 <sup>1□ M</sup>	- 12		rs. Months Days	Hours Min.	8. Date of Birt (Month, Da 09/03/	1910 Co	MD MD
land ow		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town	or Location				10d. Inside City Limits
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evantine must be notified at	Director	MD N/A		В	ALTIMORE				1 Yes 2 □ No
vith the		10e. Street and Number	WE #24		10f. Zip Code	1208		10g. Citizen of What Co	ountry?
er death w items 23a	Funeral	7208 CHALKSTONE DRI	Was Decedent Ever	in U.S.			pecify Yes or No	USA - 14. Race - Ame	rican Indian
after d		1 □ Never Married 2 □ Married 1	Armed Forces? □ □Yes 2 XI No		13. Was Decedent of H		Rican, etc.)		e, etc.
nours a	d by	3 X Widowed 4 □ Divorced	fYes, Give rear or Dates:		1 □ Yes 2 🛣 No	Specify:		Specify: WH	
n 72 h n "natu	Completed	15. Decedent's Educatio (Specify only highest grade cor	mpleted)	(	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of worl	king	16b. Kind of Business	Industry
d withi giene. er thar	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		RECEPTIO			BETTER BUS	INESS BUREAU
be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
d Men narke	P P	JOSEPH		HOWITZ		REBE			CAPLAN
Pages 1 and 2 should be filed within 72 hc nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natur iry or other traumatic event, the Medical		19a. Informant's Name/Relationship (Type. F RITA SOLLOD / DAUGH			Mailing Address (Street 080 N. POLL				
of Head		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remo	2	20b. Place of I	Disposition (Name of crematory or other place	ce)	Date	20c. Location - City or	·
t. Pag tment tant: ijury o		4 □ Donation 5 □ Other (Specify)	oval from State	BETH	TFILOH CONG	1	1/2009	BALTIMORE	
permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licensee	the		22. Name and Addre	- 50		ISON & BROS PIKESVILLE	•
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the ause on each line.	death. Do no	ot enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	17/5	hei	men,	1)1300	250		Oriset and Death
Examiner			Due to (or as a co		Bokin	25/70	nobe	some	
- p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co			,		3 9 9	
executed in and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	The constant	4041	NINE	-		
our be	= 1		Due to (or as a co	nisequence of	.,.				
rtificati ng phy as the	Medic						***		
ath cer ttendir or use	an/N	in the past 12 months?	f yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death	3 ☐ Ectopic pregnand	су		23d. Date of de Month	livery Day Year
The law requires that the death certificate tee has been signed by the attending physicage 2 should be detached for use as the I	Physician/Medica	1 TVes 2 TNo	4 □ Pregnant at tim 9 □ Unknown	e of death	5 ☐ Other (specify) _			World	Day Teal
w requires that the diberen signed by the should be detached	by Ph	Part II. Other significant conditions contribu	uting to death but no	ot resulting in	the underlying cause giv	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
equire een sig ould b	ted b	0846000 This					1 🗆 ነ	Yes 2 No 3 P	robably 4 Unknown
e law r has be e 2 sh	Completed	OLFOBORO	225				24a. Was	osy prior to	utopsy findings available completion of cause of
		05.00					1 □Yes	rmed? death? 2 ☐ 40 1 ☐ Yes	
/slcia s certi	To Be	25. Was case referred to medical examiner?  1 Yes 2 Ho  Hosp	ital:	2 □ EB/Out	patient 3 DOA Oth	26. Place of Dea		dence 6 Hother (Spe	A STITLED
Attending Physician: r death. ector: After this certifics by the funeral director, p		27. Manner of Peath 2 1 ☐ Matural 5 ☐ Pending	8a. Date of Injury (Month, Day, Ye	28b. Ti				how injury occurred	(City)
tendii leath. tor: A the fu	catic	2 Accident investigation			M 1 □	]Yes 2□No			
al or At after of I Direct d in by	Certification:	4 Homicide determined	:8e. Place of Injury - building, etc. (\$	· At home, fari Specify)	m, street, factory, office		28f. Location (3 City or Tov	Street and Number or R wn, State)	ural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	an: To the best of m On the basis of exa and manner stated	amination and	death occurred at the ti	ime, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) and manner a date and place, and dur	s stated. e to the cause(s)
To th	M	29b. Signature and title of certifier	Lucion	- In W	29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
12 1		30. Name and address of person who complete the control of the con	eted cause of death	(Item 23a) (	Type, Print)	1. Ves	<i>ع</i> لاو	Mans	80616
Sta Registr		31. Date filed (Month, Day, Year)	32. Ri gietrar's		barke			A Table	~ 2 1400
OHMH 17 Rev 1/2		FFR T \$ 5008	PROBLEM	B.	i garre	_			

		•	For State Registrar	State of N	/larylan		artment of H		•	giene Reg. No. 20	09	04125
	Physicia	an	1. Decedent's Name (First, Middle, La						2. Date of De Month	ath Day	Year	3. Time of Death $S = 35 \text{ G/M}$
	/Medic Examin	al	Doris Jeanette  4a. Facility Name (If not institution, gi	e street and number	er)	/.	4b. City, Town, or	Location of Death	02-	4c. County	of Death	8:35
Ť	Funeral		,	Sex 7.7	<i>  (en f</i>     Age <i>(In yrs. I</i>   79	ast birthday) Yrs.	If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 13	th ay, Year)	Cour	C place (State or Foreign pland
	Director Mou		214-24-8615           Usual Residence of Decedent           10a. State         10b. County			, Town or Lo	cation		Julie 13	,1929		Od. Inside City Limits
	after death with the Maryland or items 23a or 28a-f show	Funeral Director	Md. Balto  10e. Street and Number	•		Whit	e Marsh			10g. Citizen of V	Vhat Coun	1 □ Yes 2 No
	th with	ral D	11727 Hamilton	21.			2	1162		U	S	
036	ours after dear al", or items Evanting in	<u>।</u>	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force: 1	s? <mark>X</mark> No		Was Decedent of H f Yes, specify Cuba 1 ∐Yes 2∭No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Rad Blad Specify	k, White, e	ean Indian, etc. iite
$F_{\rm U}//e_{\rm G}$ Doris Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, Immedical Exagnore.	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	r 5+)	(Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	16b. Kind of Bu	ısiness/Ind	dustry
7. C	filed v Hygie other ent, II	Be Co	12 17. Father's Name (First, Middle, Las	<u> </u>		Homen	laker	18. Mother's Nan	ne (First, Middle	Home , Maiden Surnam	ne)	
Jan	uld be Menta arked atic ev	To B	John Horky					Ada Du	valle		_	
Mar	12 sho th and 7 is ma trauma		19a. Informant's Name/Relationship	(Type. Print)			ng Address (Street			-		
//e	s 1 and 2 f Health item 27 i		Barbara Kennedy 20a. Method of Disposition		DTR. 20b. P	ace of Dispo	27 Hamilto sition (Name of matory or other place	i i	White Date	Marsh, 20c. Location -	Md . 2 City or To	.1162 wn, State
12 <b>E</b>	Pages nent of l ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		te I	ly Hil		2-9-	2009	Middle	Rive	er
Balt	permit. Departr Imports any Inje		21. Signature of Funeral Service Lice	nsee	2	22	2. Name and Address 9705 Bela					
8	Physician /Medical		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	ine.	01	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
3	Examiner		Sequentially list conditions	b.	as a consequ	ierice oi).						
1/2	nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		as a consequ	ence of):						
) E // 8760,	cate be executed ohysician and the burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or a	as a consequ	ience of):						
(10 M) O. Box 68	death certifi e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Fetal tat time of d	death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у			te of delive	ery Day Year
ds, P	requires that the		Part II. Other significant conditions	contributing to death	but not resu	_	nderlying cause give	en in Part I.		tobacco use cont	ribute to th	ne cause of death?
P+T Recor	ie law requ has been ge 2 shouli	Completed by	Colorectal F	istula					24a. Was	an 24b.	Were auto prior to co death?	psy findings available mpletion of cause of
ta &	an: The tificate h or, page		Diverticulit 25. Was case referred to medical	15				26. Place of Dea	1 □ Yes	2 12 No	1 □Yes	2 □ No
of Vi	Physicia rthis certi ral directo	To Be	examiner? 1 ☐ Yes 2 ☐ No			ER/Outpatier	nt 3 DOA Oth	05:		dence 6 ☐ Oth	er (Specif	(y)
	tending Peath.	tion:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of I (Month,	njury Day, Yea <i>r)</i>	28b. Time o Injury	Worl	yat <br Yes 2∐No	28d. Describe	how injury occur	red	
Division	l or Atten after deatl Director:	Certification: To	2 Accident Investigate 3 Suicide 6 Could not 4 Homicide determine	28e. Place of	Injury - At ho etc. <i>(Sp</i> ecify	me, farm, str	eet, factory, office	103 2 100	28f. Location ( City or To	Street and Numb wn, State)	er or Rura	al Route Number,
	e Hospital 124 hours e Funeral letely filled	Medical C		hysician: To the be miner: On the basis and manner	s of examina							
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens		,	29d. Date signe		
		18	30. Name and address of person who	completed cause of	of death (Item	23a) (Type,	Print) KINSQU	16/1	) /	1-65	>	201
_		t S	Dr. Brian Jam	es Karp	9000	Fran	Klin Squ	are Driv	e Balt	intere, p	10 21	1237
	Sta Registi		31. Date filed (Month, Day, Year)  FFR 1 2 2009	32. Regi	strar's Signa	fax				-		

			ForState	State of Ma	ryland / Dep	artmer <i>rtificat</i>			- 1	0000	04126
			Registrar	-41		lillicat	e oi L	Jealli		2002	0
	Physicia	ın	Decedent's Name (First, Middle, Last						<ol><li>Date of Dea Month</li></ol>	Day Year	3. Time of Death
	/Medic	al .	ALPHONZO		WI-KES				02	09 200	
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City,	Town, or	Location of Death		4c. County of Dea	ath
er/E			5217 FREDER					Move If Under 24 Hrs.			
	Funeral		5. Social Security Number 6. S	ex 7. Age Maria Dari	(In yrs. last birthday	Months	Days	Hours Min.	8. Date of Birt (Month, Day	y, Year) C	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		もと Yrs.				03/27	1926 1	rdinia
	and and	}	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	f sho	ō	4.4 %		0						1 XYes 2 No
	the N	Director	10e. Street and Number		BALTI	10f. Zip				10g. Citizen of What C	ountry?
	with					10 2.,					
	eath	Funeral	5 2 17 FREDCY	12. Was Decedent 8	verinUS 13	Was Dece		ispanic Origin? (Spe	ecify Yes or No-	14. Race - Am	
	ter d	ᇤ	1 Never Married 2 Married	Armed Forces? 1 ¥Yes 2 ☐ N		If Yes, spe	cify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Whi	
9	irs af	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	}_	1 □Yes	2 No	Specify:		Specify:	Rican-AM
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Modeal Examine must be inclined at	ted ed	15. Decedent's Ed	lucation		edent's Usu				16b. Kind of Business	
2	in 72 in "in Madi	Completed	(Specify only highest gra	de completed) College (1-4or 5-	life.	e kind of wo DO NOT u	rk done d se retired	during most of worki i)	ng		
2121	with giene r tha	E O	Elementary Georgiany (0-12)	College (1-401 3-		SUPF	مدح	LLevk		C+P Tele	phone
ğ		Be C	17. Father's Name (First, Middle, Last,					18. Mother's Name	(First, Middle,	Maiden Surname)	
<u>ā</u>	should be filed within 72 hours after death with the Marylan marked bygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Modical Evan instructions to rutified at	10 E	WAVENLY F	DWILLES				ALIC	e_ w	NOTIA	
aryland	12 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (		19b. Mai	ing Address	(Street			er, City or Town, State,	Zip Code)
≥	C m cv -		Reue Fowl	V-s	52	17 6	Per	DOVOST	20 B	ALTIMOVE	PS.SIS AL
ล์	s 1 and of Healt item 2		20a. Method of Disposition		20b. Place of Disp cemetery, cre				Date	20c. Location - City o	
Ê	0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		MCHDOW				Propels	ElKridge	A4D
altimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licer		Mentoon	2. Naipe a	nd_Addres	ss of Facility	Fune	al Services	, 7010
ä	Dep Imp any		Varial C	1,000	C	(151 -	anu	C. Greene	Pike (=	212291	
			23a. Part 1. Enter the disease, or com	plications that caused	the death. Do not e	nter the mo	le of dyin				Approximate
	DI	6 3	shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	e.		-				Interval Between Onset and Death
100	Physician /Medical		disease or condition resulting in death)	W	a consequence f):	1	Ca	reinom	alle,	ς	4 weeks
	Examiner			1 000	66 P550+5500		2	rcino m			0100000
		e.	Sequentially list conditions,		i eunsequenes of):		un	week			S VILLUS
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	_							
	exec in an	Exa	resulting in death) Last	Due to (or as	a consequence of):						
8760,	cate be executed physician and the burial-transit	dical		d							
9	tifical g phy as th	edi									
ŏ	h cer endir use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐ Ectopic	roanono	.,		23d. Date of d	elivery
ω .	deat e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	4 🔲 Pregnant at		Other (s		у		Month	Day Year
Ö	t the by th tache	hys	9 ☐ Unknown	9 ☐ Unknown							
Vital Records, P.O. Box	s tha gned e del	by P	Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying	ause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Ë	quire en sij	ba							10	Yes 2∏No 3∏I	Probably 4 Unknown
ပ္တ	aw re is bei	Completed							24a. Was		autopsy findings available
ď	The I	E							autor perfo 1 □ Yes	rmed?   death?	completion of cause of
<u>a</u>	an: rtifica tor, p	Be C	25. Was case referred to medical					26. Place of Deat			.5 2 1110
>	ysici is ce direc		examiner? 1  Yes 2  Mo	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpati	ent 3 D	Oth	er: 4 🗆 Nursing Ho	me 5 🛣 Resi	dence 6 ☐ Other (Sp	pecify)
Division of	g Ph terth	Ë	27. Manner of Death	28a. Date of Inju (Month, Day	ry 28b. Time	of	28c. Injur Worl	ry at		how injury occurred	
<u>ō</u>	ath. r: Af	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		, reary injury	М		Yes 2 □No			
<u> </u>	Atte	iitic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		iry - At home, farm, s	treet, factor	y, office		28f. Location (a City or Tox	Street and Number or I	Rural Route Number,
Ö	talon rsaft al Din ed in	Certification: To			. 1 ***/				J., 0, 101	,	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours atterdeath.  To the Funeral Director: After this certificate has been signed by the attending propietely filled in by the funeral director, page 2 should be detached for use as									cause(s) and manner date and place, and de	
	the H sin 24 the F	Medical	one)	and manner sta					. 55 5. 110 11116,		
	Viit To 1	Σ	29b. Signature and title of certifier	m				e number		29d. Date signed (Moi	
			· Mu	+	MD		DY	5274		2/11/0	
	Q		30. Name and address of person who	•		e, Print)		5274 Caro		MDZI	
	0 🗸		Cho Morny MD.	516 N	Rolling R	al t	30	Caro	nsville	MD21	23-5
	Sta		31. Date filed (Month, Day, Year)	32. Resistr	ar's Signature						
	Registi	ar	FEB 1 22	1009 Lener	va B.	Backs	S.				

09-01160	
Charles Gunther	

ease	Type or Print in Black Indelible Ink. Ensure All Copies Are Leg State of Maryland / Department of Health and Mental Hygiene  Certificate of Death	gible.	2009	0412

07.0				For State	O.C.	0 0	7	Certi	ificate of	Death			Reg		.00		0-711-
	Physic	cian	1	egistrar . Decedent's Name								M	ate of Death	Day \	Year		of Death
Medi	cal Exan	nine	T	CHARLES						011 7			bruary 8,		ity of Deati		.11115
7	*		4	a. Facility Name (i 3215 Gulfpo		give stree	et and number)			b. City, Town, or Baltimore	Location of		415	1 5	N/A		
	Funera	al	5	. Social Security N		Sex		je (In yrs. las	t birthday)	If Under 1 Year Months Day		24Hrs. 8.	Date of Birth	(MM/DD/YY	Forei	an	
	Directo	or 		214-76- Usual Residence o	7000	X <sub>M</sub>	2F	48	8 Yrs	Months	riodis		2-19-	1960	Co	ountry MA	ARYLAND
	any		_	0a. State	10b. County			10c. City, T	own or Locati	on							side City Limits
1	*	j ,	_	MD.	N/A			BA	LTIMOR	E						1 X	Yes 2 No
W.	farylar	Diroctor		0e. Street and Nu						10f. Zip Code			100	g. Citizen of	What Cou	untry?	
W	with the Maryland			3318 BU	RLEITH					2121				US		dana landi	an Diagle
1	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she unt: If item 27 is marked other than "natural",	st be n	runerai	1. Marital Status  Never Marri	ied 2 X Mari		Was Deceden Armed Forces		5. 13. Wa	s Decedent of H es, specify Cuba	ispanic Origi ın, <b>M</b> exican,	n? ( Specify Puerto Rica	Yes or No- in, etc.)		ace - Ame /hite, etc.	rican indi	an, black,
	ler de	-	- 1	3 Widowed	4 Divor	ced If Yes	Yes 2 , Give Year	No	1	Yes 2 X N	o specify:			Speci	ify: BL	ACK	
	ours al		<u>6</u>  -	15. Decedent's E	ducation (Specif	y only hig	hest grade co	mpleted)	16a. Deceder	t's Usual Occupa	ation (Give k	ind of work use retired)	done	16b. Kind o	f Business	/Industry	
	6 172 hc 19 m "un	Cal Es		Elementary/Sec		(	College (1-4 or	5+)	3			,		CHIE	YARD		
	5-0036 led within 72 tygiene. other than	Med	Completed	-12		act)	-0-		MAC	HINIST	18. Mother's	s Name (Fir	st, Middle, M				
	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than		8		GUNTER							N JOY					
	2121 ould be fil Mental I marked	ic ever	0	19a. Informant's N			Print )		1	g Address (Stre							1
	MD and 2 she alth and in 27 is	mar.			CUNTER(	MOTH	ER)	- Table 19	1	BURLEIT		• BAL		E, MAR			
	ore, MD es 1 and 2 sho of Health and If item 27 is	er fra		20a. Method of Dis		3 R	emoval from S	State Cr	rematory or of						,		
	imo Page ment c	or of	i	4 Donation 5	E Other See	oifu:		MT.	ZION	CEMETERY							RYLAND
	Baltimore, permit.: Pages 1 an Department of Hea Important: If iten	Î,		21. Signative of E	ur eral Sylvice (	icen el	ONATHAN	и D. н		Name and Addre $21-27~{ m N}_{\odot}$							
	Physicia		$\dashv$	23a. Pat I. Enter I	the disease, or o	omplication	ons that cause	ed the death.								Appr	roximate Interval ween Onset and
A. C.	/Medic			fure. List o	only one cause o	n each lir	<sub>ne.</sub> orphine									betv	Death
	xamin	er	1	Immeriate Cause or condition result	ting in death)		to (or as a con										
				Sequentially list of		b			N.		_					_	
			Ē	if any, leading to i	derlyin Cause	c.	to (or as a con	isequence of	1.								
	pa	nsit	Examine	(Disease or injury events resulting in	n death) Last	Due '	to (or as a con	sequence of	f):								
	execut an and			X UNPENDE		AN	MENDED 2	3a,27	,28a-f	, perME,	g888	2/27,	/09 TT				
	60, ate be	e buri	Medical	IF FEMALE:			3c. If yes, outc	ome of pregr	nancy						ate of delive		
	687 certifica	e as th		23b. Was deceder past 12 montl	nt pregnant in the hs?	- 1	Live birth	at time of dea			Ectopic Ectopic	c pregnancy	′	Mon	ith	Day	Year
	Box (e death of	for use as the	Physician	1 Yes 2	No 9 Unk	nown 4	_	at time of dea	5 C	other (Specify)							
	D. B t the d	ached		Part II. Other sig	nificant conditi	ons con	tributing to de	ath but not re	esulting in the	underlying caus	e given in Pa	art I.					use of death?
	P.O. res that t	be det	g S										CARLES		-20	and the second	4 V Unknown
	cords, law requirements	should	E E										24a. Was autop	sy	prior t	to comple	findings available tion of cause of
	Records, The law requir	ge 2 s	Completed										perfo 1 <b>Y</b> Yes	rmed? 2 No	death		2 No
	nn: TI	Ē	ø	25. Was case ref	ferred to medical					26.Pia	ace of Death	(Check only	y one)				
	of Vital ng Physician	<u>-</u>	To B	examiner? 1 ✓ Yes	2 No	Hosp	тпре	atient 2	ER/Outpatie		Other <sub>4</sub>	Nursing F	dome 5	Residence		her: Scen	ne
	ling Pl	funera		27. Manner of De			28a. Date of I (Month, Da		28b. Time o	,,	njury at Work Yes 2 X		nk	now injury o	COULTEG		
	Sior Attend death	y the	catic	2 Accident	Inves	tigation	Fd 2/8		FD 9:	eet, factory, offic		to 29	of Location (	Street and N	Number or	Rural Ro	ute Number, City
	Division tal or Attendirs after death.	filled in I	Certification:	3 Suicide	6 X Could deter	d not be mined	(Specify)	hous		, ,,			or Town, S Baltin	State) 32 nore,	MD Gi	ılfpo	ort Dr.
	Hospi 24 hou	etely fill		29a. Certifier		nysician:	To the best of	f my knowled	lge, death occ	urred at the time	, date and pl	ace, and du	e to the cau	se(s) and ma	anner as s	stated.	
	To the within To the	completely	Medical	29b. Signature a		and	d manner state	ed.			ense number				e signed (i		
			2	230. Signature at	(a) (2)	211	n11 . 1.	11			C.M.E.			Februa	ary 9, 20	)09	
				30. Name and a	dress of person	who com	pleted cause of	of death (Item	n 23a)								
Q	V	/		Pamela E	. Southall, M	iD A	ssistant Me			11 Penn Str	eet, Baltir	nore, MD	21201				
	Re	St	ate rar		FEB 1 2	2009		strar's Signat	ure .	arke							
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			For	State o	f Maryland						ental Hy			01.100
_			State Registrar			. Ce	rtificat	e of L	Jeatn			Reg. NO	009	04/28
	Physici /Medic	_	Decedent's Name (First, Middle,     MARVIN		RNARD		GR	EEN			2. Date of D Month FEB.	09,	2009	3. Time of Death  1:20 A-M
	Examir		4a. Facility Name (If not institution, LEVINDALE HEBR	EW HOME			BALT	IMOR					ounty of Death	
	Funeral Director		212-30-7075	3. Sex 1	7. Age (In yrs. las <b>71</b>	Yrs.	If Under Months		If Under Hours	Min.	8. Date of B (Month, D 11/25	rth Pay, Year) /1937	9. Birth Cou	place (State or Foreigr ntry) MD
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	he Maryli 28a-f sho otified at	Director		TIMORE			REIST		OWN			10g Citize	en of What Cou	1 ☐ Yes 2 X No
	with la or i		302 CANTATA	COURT #	323			2113	6				JSA	,
	ns 23 mus	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S.	13.				rigin? (Spe	cify Yes or N Rican, etc.)		I. Race - Amen	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2XX Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Formal Armed	²□Nº NAV\	1	if Yes, spe		Specify		Rican, etc.) Black, V Specify:			WHITE
2-0	72 ho natur fical I	eted	15. Decedent's	s Education grade completed		16a. Dece	dent's Usu kind of wo DO NOT u	al Occup	ation during mo	st of workir	ng	16b. Kind	d of Business/li	ndustry
21215-0036	d within giene. rr than " the Mec	Completed	Elementary/Secondary (0-12)	<del> </del>	(1-4or 5+)	`life.	CLER						SHIPPIN	G
pu	al Hygie I other i	Be	17. Father's Name (First, Middle, L	ast)							(First, Middl	e, Maiden S		
yla	should k nd Ment marked marked	은	SAMUEL		GREEN					ELIA				OPERMAN
Maryland	12 sh h and 7 Is rr traurr		19a. Informant's Name/Relationshi				0	•					Town, State, Z	
	1 and Health em 27		MARIAN GREEN / 20a. Method of Disposition	WIFE	20b. Pla	ce of Disp	osition (Na	me of	T T		ate		OWN, MD ation - City or T	
JOL	ë		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( <i>Sp</i>				matory or o VETE			02/1	1/2009	REISTERSTOWN, MD		
Baltimore,	구두막근		21. Signatur of Funeral/Service L	-	1		2. Name a						& BROS.	
ä	Depar Impor any ir		Leath III	Will	h		8900	REIS	TERS	TOWN	ROAD -	PIKE	SVILLE,	MD 21208
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that	caused the death.	Do not er	iter the mod	de of dyir	ıg, such a	s cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_a. D	YEUME	DMI	A							Oriset and Death
	/Medical Examiner		resulting in death)	Due to	Due to (or as a consequence of):									
Ь	LAMIIIII	_	Sequentially list conditions,	b										
Т	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence or).										
,	te be executed ysician and re burial-transit	Exar	that initiated events resulting in death) Last	c Due to	(or as a conseque	ence of):								
760	e berri	<u>8</u>		d										
68	The law requires that the death certificate the has been signed by the attending physing 2 should be detached for use as the	Physician/Medic	IE EEMALE.											
Вох	ath ce tendii or use	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1□Live	utcome pf pregnan birth 2 □ Fetal (	death 3	□Ectopic p		,			23	3d. Date of deli Month	very Day Ye <i>a</i> r
	ne deg the a	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preç 9∐Unk	nant at time of dea	ath 5	Other (s	pecify)						,
P.0	that the de ned by the a detached i		Part II. Other significant conditio	ns contributing to	death but not result	ting in the	underlying o	cause giv	en in Part	1.	23e. Did	tobacco us	e contribute to	the cause of death?
ds,	luires n sign	d by	DEMEN	TIA							1 [	Yes 2	Mo 3□ Pro	obably 4 ∏Unknow
or Vital Records,	w requir been si should I	Completed									24a. Wa		24b. Were au	topsy findings available
Re	The lay	dmo										topsy rformed? 2 No	death?	ompletion of cause of 2 ☐ No
ita		Be C	25. Was case referred to medical		- 27-17				26. Plac	ce of Death	(Check only			
<u>r</u> <	hysic nis ce I direc	TO E	examiner? 1 ☐ Yes 2 ☐ No			<u> </u>	ent 3□D		4 L I	lursing Hor	me 5□Re	sidence 6	☐Other (Spec	cify)
n o	or Attending Physician: ther death. Director: After this certifics in by the funeral director, i		27. Manner of Death 1 Natural 5 ☐ Pending	(Mo	e of Injury onth, Day Year)	28b. Time Injury		28c. Injui Wor			28d. Describ	e how injury	occurred	
sio	Attend death. ctor: / y the fi	cati	2 Accident investig 3 Suicide 6 Could n	ot ho	e of injury - At hon	ne farm e	M treet factor		Yes 2		ORF Location	(Street and	Number or Ru	ral Route Number,
Division	I or A after ( Direc in by	Certification:	4 ☐ Homicide determi		ding, etc. (Specify)		TOOL IAULUI	.,, оппов				own, State)	umpor or Mu	.a route ramber,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co		Examiner: On the	ne best of my know basis of examinati									
	To the within 2 To the comple	Med	29b. Signature and title of certifier		amor stated.		29	9c. Licens	e number			29d. Date	signed (Monti	n, Day, Year)
	F > F O							_						

Pluza H. Word CHOWN

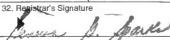
D0063327

FEB, 9, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W. BELVEDERE AVE. BALTIMORE, MD 21215 GIZAW WOLDEHINOT, MD 31. Date filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** :28 AM ames Hammond 6 2009 /Medical County of Death 4a. Facility Name (If not institution, give street and number) ity, Town, or Location of Death Examiner Randallstown Baltimore Koao loleon Social Security Number If Under 24 Hrs Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1**M**M 2□F Months Days 84 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Show r 28a-f show notified at 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7407 21133 sad olean death v Funeral 14. Race - American Indian, Black, White, etc. 7 is marked other than "natural", or Items traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 <u>م</u> 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconds (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+)  $p_i$ no 18. Mother's Name (First, Middle, Maiden Father's Name (First, Milddle, Last) Surname) Be tammono 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) allstown, mid 21133 Kand Barbara H. Simms Jister oleon other t 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sum of Funer \$ ervice Licens Nat sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed Yes 2 □ No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Chi Hospital: 1 ☐ Inpatient Other: 1 🔲 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5

☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury ours after death.
neral Director: A 2 🗆 No 1 Tyes 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of cert 29c. License number 29d. Date signed (Month. Day, Year) of death (Item 23a) (Type, Print) Rd, # 202, 05 Fr egistrar's Signature 31. Date filed (MoMin) Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 0 0 9

Certificate of Death Reg. No.

			For State Of F State Registrar		rtificate of Dea		Reg. No		
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  20dith, Ann, Howa	ard			Nate of Death Month O Da	y31 Year 200	3. Time of Death 14 '. 260 M
+ ARRANIE	Examin		4a. Facility Name (If not institution, give street and number Volversity of Manyland A	ledical Centr	4b. City, Town, or Locat			County of Death	C1
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8. Durs Min. (/	ate of Birth Month, Day, Year)	3alhn 9. Birth Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	51 Yrs.		Se	pt. 8,195°		RK, PA
	/arylan f show	or	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the lor 28a-	Director	10e. Street and Number	70K	10f. Zip Code	····	10g. Cit	izen of What Cou	ntry?
	heath w	Funeral	320   E. Market St.  11. Marital Status   12. Was Decede	Apt 106 nt Ever in U.S. 13. \	Was Decedent of Hispanic If Yes, specify Cuban, Mer	C Origin? (Specify	Yes or No-	14. Race - Ameri	can Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Evanting must be notified at once.	by	Armed Force  1 Never Married 2 Married 1 Yes 2  1 Yes 2  If Yes, Give Year or Date	⊋No		xican, Puerto Ricar ecify:	n, etc.)	Black, White,	
21215-0036	nin 72 ho r. In "natur Vedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4c)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. K	ind of Business/In	dustry
	iled with Hygiene ther tha nt, the	Com	17. Father's Name (First, Middle, Last)		LILITY OPE	VEATOR  Mother's Name (First		uffer Bis	cut Co.
/land	uld be f Mental I arked of tic eve	To Be	Irven Beck		10.10	Path ()	Vanme	1. 1	Beck
Maryland	d 2 sho Ith and I Ith and I Ith aums		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and No		ute Number, City o		•
	of Hea		20a. Method of Disposition  1 Di Burial 2 Di Cremation 3 TRemoval from Sta	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	ne, Gl Date		ocation - City or To	0 327 own, State
Baltimore,	artment ortant: I Injury o		4 Donation 5 Other (Specify)  21. Signature of Funer Service icensee QN	2 Suburban V	Memorial Gards 2. Name and Address of F	Feb. 6,2	DANNE	VER PA	
Ba	permi Depar Impor any Ir		Foratte O.A	US_ 82	22-830 E. MA	RKET ST.	YORK, PA		1 HOLLE
-	Physician		23a. Part 1. Enter the disease, or complications that caus shock or heart failure. List only one cause on each immediate Cause (Final	sed the death. Do not entent in line.	er the mode of dying, suc	h as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
,)	/Medical Examiner		disease ( condition resulting in death)  Due to (or	as a consequence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):					
6	rificate be executed ng physician and as the burial-transit	Examiner	that initiated events c.	as a consequence of):					
68760,	ate be physicial the buri	lical	d						
Box 6	onding puse as	n/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the second of the second o		7	÷10		23d. Date of deliv	ery
P.O. B	the death by the atte ached for	by Physician/Medical	in the past 12 months?	nt at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
	quires that an signed I		Part II. Other significant conditions contributing to deat	n but not resulting in the ur	nderlying cause given in P	Part I.		use contribute to t	he cause of death? bably 410 Unknown
Records,	To the Hospitel or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Completed					24a. Was an autopsy performed? 1 □Yes 2 🗷 No	prior to co	opsy findings available impletion of cause of
Vital	sician: certifica rector, p	Be	25. Was case referred to medical examiner? Hospital: , im.		_ Other	Place of Death (Ch	eck only one)		
n of	ng Phys fter this neral di	on: To	27. Manner of Death 28a. Date of	atient 2 ER/Outpatier njury 28b. Time of Day, Year) Injury	11 3 1 DOA   4L	Nursing Home 28d.	5  Residence Describe how injui		fy)
Division of Vital	I or Attendli after death. Director: A I in by the fu	Certification:	2 Accident investigation	Injury - At home, farm, streetc. (Specify)	M 1 □Yes 3	28f. L	ocation (Street ar	nd Number or Run	al Route Number,
Ω	To the Hospitel or within 24 hours after To the Funeral Dirth completely filled in		29a. Certifier (X) Certifying Physician: To the be	est of my knowledge, death	h occurred at the time, da	te and place, and o	due to the cause(s	and manner as	stated.
	To the Ho within 24 I To the Fu completel	Medical	(Check only one)  2 Medical Examiner: On the basi and manner  29b. Signature and title repririer	s of examination and/or in stated.	vestigation, in my opinion,			d place, and due t	
	5 × 5 0			du	R182	79	0	1/31/	09
	1		30. Name and address of person who completed cause of Lauren Richin	of death (Item 23a) (Type,	Print) 2 S Grand	, ( , 2	a ltina a	· /UN >	1201
	Sta			istrar's Signature	S. Green	()	en i mpp) of	100 2	1 ~ 0 /
	Regist	all	FED A W ZUUJ CENTRA	I M. Harris	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per File 86 Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month 1,55 **Physician** ebruary Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Hmore General Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F Yrs. Director 153-20-9135 02/10/1926 Virginia Usual Residence of Decedent the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, its Medical Examinar must be notified at 1X Yes 2 No Director Maryland **Paltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 2441 McCulloh Street 21217 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Care 12 should be filed w h and Mental Hygier 7 is marked other th 12 Caretaker 17. Father's Name (First, Middle, Last) Morton 18. Mother's Name (First, Middle, Maiden Sumame) 8 ပ္ Professor James Mortonn Fmma Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health ar 2441 McCullch Street, Baltimore, Maryland 21217 Jesse Jones / Husband other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 permit. Peges
Department of
Important: If It
eny injury or o 1 XBurial 2 Cremation 3 Removal from State 02/16/2009 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Ligensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final preselectic Cardiovascular Physician disease or condition resulting in death) /Medical Examiner enskr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due Examiner the death certificate be executed nding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ino 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificete 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending 1 DNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M Nacam MD Amotun

DHMH 17 Rev 1/2001

State

Registrar

harled

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

CCQ 1

2 2000

md.40

Registrar's Signal

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:37 p Jan 29, 2009 Janice Jackson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 1351 South Clinton Street If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 M & F Maryland Jul 29, 1941 219-40-6373 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Baltimore n/A Maryland 10e. Street and Number 10g. Citizen of What Country 10f. Zip Code U.S.A. 21224 1351 South Clinton Street 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mercy Hospital Elementary/Secondary (0-12) College (1-4or 5+) **Environmental Services** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

Marian Simms

20c. Location - City or Town, State

Baltimore, Md.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

02/05/09

3101 Northmont Road Windsor Mill, Maryland 21244

**Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

2

Completed

Be

2

James Simms

30. Name and address of person who completed wase of death (Item 23a) (Type, Print)

301 5%

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify) 

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Tasha Ellis

20a. Method of Disposition

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 Department of H Important: If Ite any Injury or ot

Examine physician a the burial Physician/Medical 38 attending been signed by the atter should be detached for þ Be Completed Medical Certification: To To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral

certificate be executed

Division or Vital Records, P.O. Box 68760,

Xun-21.71		Este 130	ep Brothers Fune 0 Eutaw Place B	ral Service, P. A altimore, Md 212	Ž17	
23a. Part1. Epter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.				00	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	_a	on gest	10x Hear	1 +91110	19	
resulting in death)	Due to (or as a consequence	of):	1			
Sequentially list conditions,	b	5-MM	1/6- 1951	nea		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):	/ '			
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence	of):				1.11
•	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes □ No 9 □ ∪nknown	23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□ Pregnant at time of death 9□Unknown	h 3 ⊟Ectopic pre 5 ⊟ Other (spe			23d. Date of de Month	elivery Day Year
Part II. Other significant conditions	contributing to dooth but not reculting	in the underlying car	see given in Part I	23e Did tobacci	use contribute t	o the cause of death?
Part II. Other significant conditions t	contributing to death but not resulting t	in the undertying cat	ise given in Fait i.	1 ☐ Yes	1	robably 4 □Unknown
				I LI Tes	ZUNO SAUP	TODADIY 4 OTIKITOWI
				24a. Was an autopsy performed 1 Yes 2 A	death?	utopsy findings available completion of cause of
25. Was case referred to medical			26. Place of Dea	ath (Check only one)		
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA	Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Spe	ecify)
27. Manner of D ath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Time of Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		arm, street, factory,	office	28f. Location (Street City or Town, Sta		lural Route Number,
	hysician: To the best of my knowledg miner: On the basis of examination a and manner stated.					
29b. Signature and title of certifier		29c.	License number	29d. [	Date signed (Mon	th, Day, Year)
Da Z. Wal	der bi		017154	0.	2/05/2	2009

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery & Chapel

22. Name and Address of Facility

DHMH 17 Rev 1/2001

State Registrar

Division or Vital Records, P.O. Box 68760, al or Attending P after death. I Director: After t

Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURATYA 2434 W. BELVEDERE AVENUE, BALTIN 31. Date filed (Month, Day, Year)

AVENUE 32. Paglatrar's Signature

MD

D0053928

BALTIMORE

02/06/2009

-MD

, MD - 21215

BEAUM

DHMH 17 Rev 1/2001

State Registrar

Giampetroni

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** 6:25PM February 2009 Shirley Soot Manning /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bu Himon Center Randall, town, Northwest Hospital Maryland Age (In yrs. last birthday 9. Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 🔀 F 219-32-519 mari Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside Çitý Limits a or 28a-f show t be notified at 10b. County 1 Ves 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 'natural", or Items 23a -0 by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 22 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗵 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ★ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: Witem 27 is marked other tha any Injury or other traumatin exercises. AA degree (2) 215 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be mes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 2120 9 , mdi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) buttos mem. + 21. Sign of Funeral Service Licenses tease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flure. List only one cause on each line. Baeto, md. 21224 23a. Part1. Enter the dis-shock, or heart falli Immediate Cause (Final disease or condition resulting in death) Liver Failure **Physician** Year , /Medical Due to (or as a consequence of): **Examiner** Heart Failure coudestire Year Sequentially list conditions, if any leading terminates cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Renal Failure burial-transi Years Acute on Chronic and Due to (or as a consequence of): physician Physician/Medical Chronic Obstructive Rulmondy Disease Teal the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 Hypothyroidism, Anemia, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Urinary Tract Infection 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes /2 ☑ No 24a. Was an has page 2 certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 ☐ Accident 5 ☐ Pending investigation Place of injury - Al home, farm, street, factory, office building, etc. (Specify) death. 1 Yes 2 No after death. filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in 1 Seathing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) E0067620 MD

State Registrar

DHMH 17 Rev 1/2001

Northwest Houpital Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Degistrar's Signature

Va Ki

Rupeh

31. Date filed (Month, Day, Year)

FEDYYOUN

5401 Old court Road

budhay i unotallagues

2113

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician $P^{M}$ William W. McKinstray February 10 2009 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 03–30–1927 Social Security Number 7. Age (In yrs. last birthday 9. Birthplece (State or Foreign **Funeral** Months Country) Michigan 1**X** M 2□ F Director 306 22 4708 81 Usual Residence of Decedent 10c. City, Town or Location or 28a-f show notified at 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Ellicott City MD Howard the 10g. Citizen of What Country? 10e. Street end Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or in yor other traumatic event, the Medical Examiner must be or in the other traumatic event. 21042 5330 Dorsey Hall Drive #218 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Management Information Social Security Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph McKinstray Susan Joy Weer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eloise G. McKinstray/Wife 5330 Dorsey Hall Drive #218 Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Himportant: If ite any injury or of IX Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memorial Park 2-13-2009 Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Dhew Colla 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Respiratory Failure 48 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Bilateral Pheumonia 6 days Sequentially list conditions, Dise to for as a nunsequence off Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Multi-System Organ Failure The law requires that the death certificate be executed 6 days physician and the burial-tran Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Sepsis 7 days Physician/Medical as IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) by the a □Yes 2□No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Poor Nutrition 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performed page 1 Yes 2 No ector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ 1 ☐ Yes 2X No 1 Nopatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation (Month, Day Year) Injury 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: s after death. To the Funeral Dir To the Hospital

Certification: Medical

4 Homicide

(Check only one)

29b. Signature and title of certifior

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2-10-2009

PHYSICIAN D59105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M Musara MD FACS 7845 Oakwood Rd #201 Glen Burnie, MD 21061

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) 1 2 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February Marks 2009 Sandra Lee 12:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8637 Tower Bridge Way Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 🖵 F 216-56-3946 Director 58 19, 1950 Maryland Usual Residence of Decedent the Maryland 10h County 10c. City. Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☐ No Director 28a-f Baltimore Lutherville Maryland 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Walfall Exercity and proce. 8637 Tower Bridge Way 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ▼ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Marks Lorraine Francis Stevens ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Marks, Jr., (Brother) 3213 Greenway Dr., Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/16/09 Baltimore, Maryland 4□Donation 5 🖾Other (Specify) Entombment 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, rany, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 D Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown certificate has been signed by the rector, page 2 should be detached it 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural after death.

I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number cause of death (Item 23a) (Type, Print) ble Hill Co Zuthonville, Md 31. Date filed (Month, Day, Year) State Registrar

			1- For Amend Items State of Maryland Depart Registrar Certif	ment of Health and 88,02/12/09dhb ficate of Death	d Mental Hygie Reg.	ene 2009 04138					
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year					
	/Medio	al	EVELYN L. McCULLOUGH  4a. Facility Name (If not institution, give street and number) 4th	o. City, Town, or Location of De	Jan. 4,	2009 Year 9:30P M					
j	Examin	eı	27 Akin Avenue	Capitol Heig	hts,MD	P.G					
	Funeral Director			Under 1 Year   If Under 24 H Ionths Days Hours M		9. Birthplace (State or Foreign Country) 6 McCormick, SC					
	ס	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits					
	Maryla I-f sho	to	MD P.G. Capitol H			1 ☐ Yes 2 ☐ No					
	th the	Director		10f. Zip Code	10g	. Citizen of What Country?					
	s 23a	eral	27 Akin Avenue	20743	/Dit-VN-	P.G.					
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 □ Never Married 2 □ Married   1 □ Yes 2 🕅 No	Decedent of Hispanic Origin? s, specify Cuban, Mexican, Pu	erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black					
21215-0036	"natur	Completed	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kind	t's Usual Occupation d of work done during most of w NOT use retired)	vorking 16	b. Kind of Business/Industry					
212	l within giene. r than "	omo	Elementary/Secondary (0-12)   College (1-4or 5+)	ng Asst.		rivate Industry					
pu	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)		lame (First, Middle, Mai Unknown	den Surname)					
Maryland	should and Men is marke	မ		Elbert Patterson  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Run							
	and 2 s ealth ar n 27 Is ner trau					Wash., DC 20020					
altimore,	Pages 1 a nent of He ant: If Item ary or othe		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, cremato			c. Location - City or Town, State					
ij	permit. Page Department Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify) Harmony 1  21. Signature of Funeral Service Liestines 22. No.			ndover, MD ster Funeral Home					
ä	Dep Imp					, Wash.,DC20011					
	Physician and Medical Examiner  Style private transit is the purial-transit is the purial-transit is the purial transit is the puria	CT	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cai se (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			Approximate Interval Between Onset and Death					
O. Box 687 he death certificate	eath cert attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ec		23d. Date of delivery Month Day Year						
rds, P.	w requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the under	23e. Did tobac	obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown						
Division of Vital Records,	yslcian: The law re lis certificate has be director, page 2 sho	Completed		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 ※No						
Zi.	s certif	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🛣 No	Other:	eath (Check only one)	- C - C - C - K -					
ion of	nding Phy ath. r: After this e funeral d	Certification: To	27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Year)   28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2 No	Bc. Injury at Work?  28d. Describe how injury occurred						
Divis	ial or Atte s after dea al Directo ed in by th	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		2	29b. Signature and title of certifier	29d.	29d. Date signed (Month, Day, Year)						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin OPHNELL CUMBERBATCH, MD 8416 Cen	ntral Avenue	, Landove	er, MD 20785					
	Sta Registr		31. Date filed (Month, Day, Year)  FEB 1 2 2009  32. Registrar's Signature								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:22 4 M DENVISE FEB 2009 G reno A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMON ST. Agnes Hospitar Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 12-18-195 Director MARYLAND 70 0875 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner must be nofffled at 1 XYes 2 No Director MD BALTIMOVE the 10e. Street and Number 10g. Citizen of What Country? USA 21229 by Funeral BO 521 COUCUTVY Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hyglene.
ant: If tem 27 is marked other than "natural", or items 23 ant: If tem 127 is marked other than "natural", or items 23 any or other traumatic event, its "two-lical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced BUNCK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHYK CHRISTIMA HEHLTH NAIGSME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ lurner LILLIAM BAtes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any Injury or other trong once. Wender owings HUSBAND Coventry Ro. BALTIMOVE MD 21229 5al 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/19/09 BALTIMONE 21. Signature / Funeral / evice Licensee 22. Name and laddre of Freineene Fineral Services 5151 Balto. Nort'I Pilce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resuma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transi Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2.13.No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this or filled in by the funeral dire 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title/of cartifier who completed cause of death (Jem 23a) (Type, Print) Varshos 30. Name and address Da /timo SECUY IT Vel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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elores Anne Py •	1 F	legistrar	artment of		u ivientai H	Re	g. No. 🥎				
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last) Dolores Ann Pyles				2: Date of Death Month February 1		3. If me of Seath 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Tedical Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County o				
		Washington County Hospital		Hagerstown			Washing				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 M 2 X F	last birthday)  52 Yrs	If Under 1 Yea  Months Days		8. Date of Birti Nov 16	, 1956	9. Birthplace (State or ForeignDistrict of Country)Columbia			
any	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin									
<u>*</u> .	_	Maryland Washington	Sharps	sburg				1 Yes 2 No			
Maryland 28a-f show J at once.	91	10e. Street and Number		10f. Zip Code	····	10	g. Citizen of Wh	at Country?			
ith the Maryland 23a or 28a-f sho notified at once.		2830 Limekiln Road		2178			USA				
ath with	uneral	11. Marital Status 1 Never Married 2 Married Armed Forces?		as Decedent of His Yes, specify Cubar				- American Indian, Black, e, etc.			
her des	щ.	1 Yes 2 X No 3 Wildowed 4 Divorced If Yes, Give Year	1 _	Yes 2X No	specify:		Specify:	White			
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21215-00 uld be filed win Mental Hygier marked other event, the M	Be	Robert Gibson				Attilii					
nore, MD 2121 sges I and 2 should be fi nt of Health and Mental f: If item 27 is marked other traumadic event,	-i	19a. Informant's Name/Relationship (Type, Print) William Jackson Pyles, Husband						vn, State, Zip Code) Land 21782			
ore, MD es I and 2 sho of Health and If item 27 is her traumati	1	20a. Method of Disposition 20b	. Place of Dispo	sition (Name of ce		Date		- City or Town, State			
TOF		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	tro Cre	matory I:	nc. 02	/12/09	Baltim	ore, Maryland			
Baltimore, permit. Pages I a Department of He Important: If ite	1	21. Signature of Funeral Service Licensee				Of Mary	land, I	nc. ryland 21228			
		Thomas Gregor  23a. Part I. Enter the disease, or complications that caused the deal	th. Do not enter	99 Frede:	rick Roa	d Baltin	ore, Ma	aryland 21228 part Approximate Interval			
Physician /Medical		failure. List only one cause on each line.						Between Onset and Death			
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. nypertensive  Due to (or as a consequence		vascalar	discase						
	اير	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):								
	Examiner	Chisease or injury that initiated c.									
ansit ded		events resulting in death) Last  Due to (or as a consequence	,								
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	cian	past 12 months?		Fetal death 3 Other (Specify)	Ectopic pregr	папсу	Month	Day Year			
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P.O. that the ned by detach		Part II. Other significant conditions contributing to death but not	t resulting in the	underlying cause	given in Part I.			Probably 4 V Unknown			
ds, lequires	eted					24a. Was		Were autopsy findings available			
e taw r e has b	mple	{ <del></del>				autor perfo	rmed?	prior to completion of cause of death?			
I Re n: Th rtificat tor, pag		25. Was case referred to medical		26.Plac	e of Death (Check		2 140	V Tes 2 No			
Vita hysicia this ce	O B	Tes 2 No	✔ ER/Outpatie			ing Home 5	Residence 6	Other:			
n of ding P. After funera		27. Manner of Death 28a. Date of Injury (Month, Day, Year)  1 X Natural 5 Pending	28b. Time of		ury at Work? Yes 2 No	28d. Describe	how injury occur	red			
SiOr Attent r death ector: by the	cati	2 Accident Investigation 28e Place of Injury - At	thome farm str			28f. Location (	Street and Numb	per or Rural Route Number, City			
Divi	Division of Vital Records, P.O. Box 687 spital or Attending Physician: The law requires that the death certificate hours and edeath certificate has been signed by the attending py filled in by the funeral director, page 2 should be detached for use as the Certification: To Be Completed by Physician/I	3 Suicide 6 Could not be determined (Specify)		,		or Town, S					
Hosp 24 hou Frime etely fi		29a. Certifier 1 Certifying Physician: To the best of my knowled	edge, death occ	curred at the time, of	date and place, ar	nd due to the caus	se(s) and manne	er as stated.			
To the comple	Medical	one) 2 Medical Examiner:On the basis of examination and manner stated.  29b. Signature and title of certifier	and/or investig		in, death occurred	at the time, date		ned (Month, Day, Year)			
	2	29b. Signature and title of certifier			.M.E. OCA	AF.	February				
		30. Name and address of person who completed cause of death (lite	em 23a)		- 411		ļ				
		Theodore M. King, Jr., MD. Assistant Medical		111 Penn S	treet, Baltimo	ore, MD 2120	1				
St Regist	ate	31. Date filed (Month, Day, Year)  FEB 1 2 2009  32. Registrar's Sign.		aked							
Regis	area!	I LU I C COUS ( PARILLE	gigia	ACA-							

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:00 AM Doris Elizabeth Plack February 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Edenwald Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 12,1916 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F 212-12-2478 92 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f sho 1 ☐ Yes 2 X No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 800 Southerly Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by Specify: 3 ₩ Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1.2 College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry John Weber Anna Marie Eierman ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 803 South Wind Ct. Geraldine Bond/daughter Towson, MD 21204 item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
important; if ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardFeb. 13,2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Services of Dulaney Valley, P.A. 200 E. Padonia Rd. Timonium, MD 21093 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alaheimers The Dementia of /Medical Due to (or as a consequence of): Examiner ar kyn sonian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) this ( 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after death.

I Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Bruan Adorent 6) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 Sermerly Road, Towson, MA. 21256 HUCKens State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:40 p Thomas D. Price, Sr. Jan 29, 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Glen Burnie 203 Cherry Lane If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Maryland Feb 16, 1939 Director 69 220-36-2070 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Glen Burnie Director Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 U.S.A 203 Cherry Lane Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give 196 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 1961 Maryland 21215-0036 1 ☐ Yes 2 ☐ (No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1963 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Machinery & Chemical Pipe Fitter permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important; if item 27 is marked other 1 any injury or other traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Levroney Reese Price ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 203 Cherry Lane Glen Burnie, Maryland 21060 Evelyn Price Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 02/06/09 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Warn 23a. Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Autor Language Cancer a. Autor Langu Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last nding physician and use as the burial-trans Due to (or as a consequence of): Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy atter for in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury at Work? I or Attending F after death. 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 🗆 No neral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

10

the

31. Date filed (Month, May,

29b. Signature and title of certifier

(Check only one)

Hanover St. Baltimore mp 21225 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D54413

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2009 FEBRUARY 5:15 A™ COAKIE L. PIPPEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Months Hours Yrs 79 Director 1929 579-38-7455 2, NC DEC. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 3005 BLADENSBURG RD #908 20018 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ 3 X Widowed 4 ☐ Divorced Year or Dates BLACK "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

UNK 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) UNK and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY JONES JAMES BARNES ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. 10009 GREENBELT ROAD LANHAM, MD NASTASSAJA MOORE / NIECE 20706 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State METROPOLITAN CREMATORY 02-17-2009 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD Signatur 20746 DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 23a. Parl. Enter the disease, or on olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List nl/one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** HYPOTENSIVE SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner METABOLIC ACIDOSIS Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed ACUTE RENAL FAILURE and burial-tra resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No ρ Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The certificate 2 No ı∐Yes 2∭No 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 24 hours after deatl Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier FEBRUARY 5, 2009 D65305 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1500 FOREST GLEN ROAD SILVER SPRING, MD NABILA KHAN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State garke Registrar

09-01055 William Preller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		eqistrar 2. Date of Death							eg. No.	No. 3, Time of Death				
Physician/										Month Day Year 1752 hrs				
edical Examine	r	William John	Preller				-					4, 2009	of Doc	
	4	4a. Facility Name (if not institution, give street and number)  8004 New Battle Grove Road					b. City, Tov Dundall		cation of			Baltimor	re Co	unty
Turneral i	. 5	Social Security Number	7. Age (Ir	yrs. last birthd	ay)	If Under	1 Year	If Under		8. Date of Bi	rth (MM/DD/YYYY	9. B	irthplace (State or Foreigi ountry)	
Funeral Director	J	212-60-5095	6Sex	F	54	Yrs.	Months	Days	Hours	Min.	06/13	/1954		aryland
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Baltimore, permit Pages I ar Department of Hec Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other		vai IIOIII State	Ardent (	Crem	ation S	ærvi	æs.	02/3	L1/200	9 Hanov	er,	Maryland _
Baltimo permit Page Department ( Important: Injury or ott		21. Signature of Funeral Service	ce Licensee				Name and A			Arc	dent C	remation	Se	rvices, LLC
Balt permit Depart Impor injury	Ì	23a. Part I. Enter the disease,	/			1.7	522 C	onne	elley	z Dr	ive, S	teN, Han	ove	MD 21076
Physician		<ol> <li>Part I. Enter the disease, failure. List only one cause</li> </ol>	or complications se on each line.	that caused th	e death. Do not	enter t	the mode of	f dying,	such as c	ardiac or	respiratory	arrest, shock, or tr	Cart	Between Onset an
kaminer		Immediate Cause (Final disease	se a. Нур	ertens	ive ath	eros	scler	otic	car	diov	ascula	ar disea	se_	Deau
Adminer	-	or condition resulting in death)	Due to (c	r as a consequ	uence of):									
	_	Sequentially list conditions,	b	or as a conseq	uence of):									
	튀	cause. Enter Underlying Cause												
gi, d	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
		TT LAUDENDED	d.	DED 23a	,PII,27	,pe	rME,	g888	3 2/1	8709	TT			
O, be ex- siciar	edical	X UNPENDED			e of pregnancy							23d. Date	of deli	very
3760, ificate be g physici s the buri	<u></u>	IF FEMALE: 23b. Was decedent pregnant in		Live birth	of pregnancy 2	F	etal death	3	Ectop	ic pregna	ancy	Month		Day Year
Box 68 e death certif the attending ed for use as	Physiciar	past 12 months?	4	Pregnant at ti	me of death 5		ther (Spec	cify)						
Bo; death	hys	1 Yes 2 No 9		Unknown				201100	riven in E	Part I	23e Di	d tobacco use cor	ntribute	e to the cause of death?
bat the	by P	Part II. Other significant con						cause	givenini	art i.				Probably 4 V Unknow
S, P	pe pe	terminal r	enal dis	sease,	Cocarne	us				•	24a. W		o. Were	e autopsy findings availal
ords v requ s beer shoul	Completed	1									au	itopsy erformed?	prior death	to completion of cause of h?
ecc he lav ite ha	mo											s 2 No	1 🗸	Yes 2 No
m: T	Be C	25. Was case referred to med						26.Place			only one)			
Vita ysicis this ce direc		examiner? 1 ✓ Yes 2 No	Hospital:	i Inpatier		utpatier		AGG	Other <sub>4</sub>		ng Home 5	Residence 6		Other: Scene
Division of Vital Records, P.O. Box 687 tat or Attending Physician: The law requires that the death certifical all Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the contract of the funeral director.	Certification: To	27. Manner of Death	288	a. Date of Injur (Month, Day,Ye	y 28b.	Time of	f Injury		ry at Wo Yes 2		280, Descri	be now injury occ	urreu	
Sion Attendideath death ctor: /	atio		ending envestigation								20f Leastin	on (Street and Nu	mber c	r Rural Route Number, C
Division pital or Attene ours after death teral Director: filled in by the	ific	3 Suicide 6 C	could not be 28		ury - At home, fa	arm, str	eet, factory	, office I	building,	etc.		n, State)	INDEI O	A TRAINING TRAINING T
Divis Hospital or / 24 hours after Funeral Dire	Cert	4 Homicide		pecify)							d diverse the three	nauro(s) and man	ner as	stated
Ho Fu Fu		29a. Certifier 1 Certifying one) 2 Medical	g Physician: To	the best of my	knowledge, de nination and/or i	ath occ	urred at the ation, in m	e time, d y opinio	late and p n, death (	olace, and occurred	at the time, o	cause(s) and man late and place, an	id due	to the cause(s)
To the within 2	Medical		and m	anner stated.					se numbe					(Month, Day, Year)
	Σ	29b. Signature and title of cel	une						M.E.			February	, 5, 2	:009
		unazz			- N. (P 22 )									
		30. Name and address of per Ana Rubio MD.	son who complet Assistant Me			Penn	Street,	Baltim	ore, M	D 2120	)1			
JK) V														
St	ate	31. Date filed (Mphilit, Bay) Ye	2'2009	Duran	's Signature	160	while I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20091 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February **Physician** 11, 2009 Barbara Lee Ritter 11:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1425 Pleasant Valley Drive Baltimore Catonsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 15,1935 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Months Hours **Director** Maryland 213-32-6840 Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 X No Funeral Director Catonsville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 1425 Pleasant Valley Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Laborer Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsworth E. Jordan Wilma A. Rogers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1425 Pleasant Valley Drive Catonsville, Maryland2122 <u>John A. Ritter, Husband</u> Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/12/09 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name an Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed y physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2¥☐No P.0. ed by the 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed After this certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation after death.

Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours To the Funeral Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the cause of the 29a. Certifie Medical (Check or one) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) buenn 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician aenSor UL \*/Medical Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N Ja If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Security Number **Funeral** 1 M 2 LF Director (ardina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1'√Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 3 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 2 No 1 ☐ Yes Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) marked other than Elementary/Secondary (0-12) A 200 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) grand S permit. Pages 1 and 2.
Department of Health an Important: if Item 27 is any injury or other trau daughter 24 Deirde W. Lexinst m 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 22. Name and Address of Facility 70 warch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia cause (Final diseas condition resulting in death) Physician nanition ow weeks /Medical Due to (or as a consequence of): Alphamen Type many years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 □ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🖺 Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Examiner** death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, ned by the a certificate has been s rector, page 2 should To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

Baltimore, Maryland 21215-0036

2 should be fi and Mental F

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

and manner stated.

127541

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 76611,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALETHA RAJA, 4867 Hollins Feny Del, Suite 4A, Baltimore, MD-21227 31. Date filed (Month, Day, Year) 32. Registrar's Signature

			1 - For State Registrar	State of Marylar	Ce	ertificate of	ieaith and iv Death		leg. No.	09	04141
ì	Physici /Medio		Decedent's Name (Figer Middle, Las	and V.	R	eeke		2. Date of Dea Month Februar	th Day	Year 2009	3. Time of Death 9:50A M
	Examin		4a. Fecility Name (If not institution, give 116 Carroll Road	street and number)		4b. City, Town, o	r Location of Death			nty of Death	do1
	Funeral Director		5. Social Security Number 6. Sec. 213-34-9332	לא ססר	last birthday 9 Yrs.			8. Date of Birtl (Month, Day July 26			lace (State or Foreign try) MD
	n the Maryland r 28a-f ehow	or	Usual Residence of Decedent		y, Town or L		_			11	0d. Inside City Limits 1 ☐ Yes 2 X No
	death with the Maryland me 23a or 28a-f ehow finust be mulfiled at	il Director	10e. Street and Number 116 Carroll Road	ide1 Gie	n buri	10f. Zip Code 21060			U.S.A.		try?
036	be filed within 72 hours after death with that Hygiene. Id other than "natural", or Itame 23e or event, the Medical Exeminar must be	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2\tilde{Y} No If Yes, Give Year or Dates:	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 █ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bi	ace - Americ lack, White, o	etc.
9500-61212	"natur	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece	edent's Usual Occup e kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of		,
717	e filed within Il Hygiene. other than vent, the M	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		upervisor	2)			imore r Depa	City rtment
yland		Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			ame)	
	s 1 and 2 should be f Health and Mental itam 27 is marked o other traumatic eve	To	Joseph Raeke  19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ing Address (Street		ine Deri al Route Numbe		n, State, Zip	Code)
, mar	is 1 and 2 is of Health ar itam 27 le other trau		Mrs. Charlotte F.		116	Carroll R	Road Glen				
saitimore,	permit. Pages 1 a Department of He Important: If itan eny Injury or oth		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	nemoval nom State	edar H	osition (Name of smatory or other place iill Cem.	Feb.	13,2009		yn, MI	)
gall	permit. Depart Import eny Inj		21. Signature of Euneral Service Licent	Molis		2. Name and Addreservices P					
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or compshock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	uence of):						Approximate Interval Between Onset and Death
08/pn,	tificate be executed ig physician and as the burial-transit	ledical Ex	l	Due to (or as a conseq	uence ot):						
O. BOX	death cer e attendir id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	I death 3	□Ectopic pregnancy □ Other (specify)	,			Date of delive Month	ry Day Year
rds, r	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the i	underlying cause giv	en in Part I.	23e. Did to			e cause of death? ably 4 Unknown
	The lay ete has page 2	Completed						24a. Was a autop perfor	sy	b. Were autop prior to con death? 1  Yes	osy findings available inpletion of cause of
Vital	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ № 6	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 30 DOA Dth	er: 4 Thursday Ve	h <i>(Check only or</i> me 5 Resid		wh /0 4	
	Attending Physr death.  ctor: After this by the funeral dii	-	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury	y at	28d. Describe h			//
DIVISION	P S S S S	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specif	y)			28f. Location (S City or Tow	n, State)		
	To the Hospital within 24 hours a To the Funeral Completely filled	<b>led</b> ical	(Check only 2 Medical Exam	valician: To the best of my kno iner: On the basis of examina and manner stated.	ition and/or in	rvestigation, in my o	pinion, death occur	red at the time, o	late and place	e, and due to	the cause(s)
	To To	M	29b. Signature and title of certifier	ompleted cause of death (Item 1600 S. Cross 32. Registrar's Signa Abress A.	7	29c. Licensi	1 Sto	P	9d. Date sign	lea (Month, l	OBY, Year)
0	$\checkmark$		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type	Print)	GL. R	1 - 1 - N	مر د مر	1061	(
To the second	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 2 2009	32. Registrar's Signa	iture	1	1 CICAN	~~,[	10 54		
DHI	4H 17 Bey 1/2/	7 3	LED T S Z Z Z Z	promoved to.	CALLACTURE .						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Herbert Calvin Shawker 10, 2009 11:46 A<sup>M</sup> February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10535 Bird River Road Middle River Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days 60 214-46-1045 1948 Maryland OCT 6. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐Yes 2 No Baltimore Middle River 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21220 USA 10535 Bird River Road 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No If Yes, Give 1967-year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 □ Never Married 2 □ Married 1 □Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) Audio Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Music Mixer / Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christina Weber Calvin H. Shawker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 331 Whitfield Rd Catonsville, MD 21228 Lennart Shawker/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2/11/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1+rtenosc tie Casdiovarculard isaas disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

Completed

Be

MD

7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, 1% Medical Exarciant is ust by motified at

72 hours after

3 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than ".

permit. Pages 1 and 2 and 2 bepartment of Health an. Important: If item 27 is many injury or other.

3altimore, Maryland 21215-0036

certificate be execute Box 68760.

P.O.

Division of Vital Records,

Hospital or Attending

Examiner sician and burial-trans physician at the burial Physician/Medical attending p signed by the a \$ cate has been si page 2 should b Completed certificate Be Certification: To this funeral After after death filled in by the To the Hospital of within 24 hours a To the Funeral D

27. Manner of Death

IF FEMALE: 25. Was case referred to medical

4 Homicide 29a. Certifier (Check only one)

examiner? Yes 2 □ No

1 Natural 2 Accident

3 Suicide

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a Was an autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 □Yes 2 No

28d. Describe how injury occurred

29b. Signature and title of Cortifier

5 Pending

investigation

6 Could not be determined

ompleted cause of wath (Italia 23a) (Type, Print)

1 Inpatient

28a. Date of Injury (Month, Day, Year)

29d. Date signed (Month, Day, Year) 102009

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No

irumpl 32. Registrar's

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year lores **Physician** orugry 9 12:31#A M 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HEAL Theare Age (In yrs. last birthday)
Yrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex **Funeral** 1 □ M 2 🗹 F Months Days Hours Min Director 07-10-1927 Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widfoil Evanibut outsit be notified at once. State 10b. County 10d. Inside City Limits Baltimore 1 Ves 2 No **Funeral Director** Street and Number 10g. Citizen of What Country? RICIGE Rd.
12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 □Yes 2 ☑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify \$ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Battimore Co. Schools eacher Father's Name (First, Middle, Last) Mother's Name (Finst, Middle, Maiden Surname, Be Ihrower ျ 19a. Informant's Name/Relationship (Type. Print) chunkle) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2196 Riverbrook Rd Alexander Decatur, GA 30035 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Windsor Mill, MD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facil Voughn CIRCUL FULLERAL SERVICES of Funeral Service bicensee Baltimore Nat I Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician atherosilerotic Cardiovasular +CV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner iabetec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Stal attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s autopsy After this certificate 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 24 hours after death.

Funeral Director: After thi letely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Mason Tonya 31. Date filed (Month, Day, Year)
FFR 1 2 Registrar's Signature 32.

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('a

on Ave

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 09, 2009 5:20 P. Catherine Spurley R. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pasadena Assisted Living Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days 1 □ M 2 🕅 F 88 218-07-4605 Yrs. **Director** May 04, 1920 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21122 United States of America 668 213th Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □xNo Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Motor Vehicle Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12 Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ William Spurley Carrie (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other troonce. (Niece/POA) 7789 New York Lane, APT. K, Glen Burnie, MD 21061 Pat Harrison 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 2/13/2009 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licensee 40105C 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Ent. In e disease, or complications to a caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, e ment Immediate Cause (Final **Physician** Lev/ disease or condition resulting in death) /Medical Durato (or as a masequence Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Urnerfying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner and Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 2 No 1 □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **会** 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 E-No 1 ☐ Yes 2 ☑ Me 1 □Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of To completed cause of death (Ite 3a) (Type, Print) Tokaky in D Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 1:15 A M elen Laverne 4c. County of Death 4a. Facility Name (If not institution, give street and number) Harford Jarrettsville Advocate Hill Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 409 48 06 41 Usual Residence of Decedent 1 □ M 2 💢 F 73 10d Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Advocate Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify: White 3 ☐ Widowed 4 Divorced Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hame 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Roy Thompson Nellie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SARRETTSVILLE, MD 21084 HILL ØD. ADVICATE Larson Daughter Bever 4 Lax 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/11/2009 ANATOMY GIFTS DELISTRY HANOUAR MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MUNICIPAL UNIONAL TO TENSOR CONTENS TO THE THORACOUR MIS 31076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final yais Renal failure disease or condition resulting in death) Due to (or as a consequence of): ASCUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2₽No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work?

Examiner attending physician and for use as the burial-transi Box 68760. The law requires that the death certificate be P.O. been signed by the should be detached Division of Vital Records, certificate has b irector, page 2 sh spital or Attending Physician; The hours after death.
neral Director: After this certificate y filled in by the funeral director, par

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, III. IV. Jida Examiner must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important: If item 27 is marked any Injury or other to

**Physician** 

/Medical

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical à Completed Be Certification: To

Medical

State

1 Tyes 2 100 9 Unknown

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

nd

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number D31295

29d. Date signed (Month, Day, Year) -2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21206

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

Wand Kloes 31. Date filed Month, Day, Year)

"32. Registrar's Signature

Registrar DHMH 17 Rev 1/200

To the Hospital o within 24 hours af To the Funeral Di

09-01224 John Taylor

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registra 2. Date of Death Physician/ Decedent's Name (First, Middle, Last) Month Day February 10, 2009 1006 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Sinai Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Davs Hours Director 10 Country) -8128 1 X M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No MD28a-f show **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married Yes 3 X Widowed Yes 2 X No specify: If Yes, Give Year 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) d other than ", 72 Baltimore, MD 21215-0036 filed within boler permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thin jury or other traumatic event, the Med Father's Name (First, Middle, Last) Be City or Town, State, Zip Code! Baltimore, 20b. Place of Disposition (Name of ce crematory or other place Cremation 3 Baltimore, mD 2.16.09 Other Specify: Signature of Juneral Service License P:14 (21229) Nat'I 5151 P salto. 23a. Part I. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Approximate Interval **Physician** een Onset and failure. List only one cause on each line /Medical Death Acute and chronic cerebral infarcts with Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Complications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, PII, 27, perME, g890 4/29/09 TT X UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Neuro-degenerative disease; atheroscleotic Completed 24a. Was an 24b. Were autopsy findings available cardiovascular disease prior to completion of cause of autopsy death? ✓ Yes 2 No 1 🗸 Yes 2 No After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient examiner? Other<sub>4</sub> DOA Nursing Home 5 Residence 6 ER/Outpatient 1 V Yes ۲ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Δ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E February 11, 2009 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Day Year) 2 2009 32. Registrar's Signature State Roward Registrar

DHMH 17 Rev 1/2001 OCME 2006

		_ FOF	partment of Health and Nertificate of Death	Mental Hygiene Reg. No. 2009 04153
، Physici	ian	1. Deceden's Name (First, Middle, Last) Thomas Davis Truitt		2. Date of Death Month Day Year 3. Time of Death
/Medio Examir		4a. Facility Name (If not institution, give street and number)  2 Reed Court	4b. City, Town, or Location of Death Chestertown	February 7, 2009   7:00 A <sup>M</sup> 4c. County of Death  Kent
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 202−18−8558 1 3 M 2 F 79 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania
2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modical Evantinat must be notified at	Director	Usual Residence of Decedent	cown	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
s 23a or 2 nust be n	eral Dir	10e. Street and Number 2 Reed Court	10f. Zip Code 21620	10g. Citizen of What Country?  U.S.A.
urs after de al", or item Evarringe	by Funeral	11. Marital Status  1 □ Never Married 2 【 Married  1 □ Never Married 2 【 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ 【 X Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto     □Yes 2☑No Specify:	necify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
permit. Pages 1 and 2 should be hied within 72 hours after death with the Maryla Department of Health and Mantal Hygiens. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat must be notified at once.	Completed	(Specify only highest grade completed) (Gin Elementary/Secondary (0-12) College (1-4or 5+)	sedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	16b. Kind of Business/Industry  Computer
d be nied ental Hygiked other	To Be Co	17. Father's Name (First, Middle, Last)  Joseph Alexander Truitt	-	e (First, Middle, Maiden Surname)
nd 2 snour alth and M 27 is marl r traumati	Ĕ.	19a. Informant's Name/Relationship (Type. Print) 19b. Ma		ral Route Number, City or Town, State, Zip Code)
Pages 1 a nent of Hea int: if Item iry or othe			ematory or other place)	Date 20c. Location - City or Town, State  1/2009 Hanover, MD
permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee		atomy Gifts Registry ve, Ste.P, Hanover, MD 21076
Physician /Medical Examiner portage principle	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Prostato Conce	Interval Between Onset and Death
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic		B ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
quires tirat in signed b	δ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ 4 ☐ Unknown
icate has bee r, page 2 shor	Completed			24a. Was an autopsy performed?  1 Yes 2 1 No 1 Yes 2 1 No 2 1 Yes
this certifial directors	To Be	25. Was case referred to medical examiner?  1	ient 3 DOA Other: 4 Nursing Ho	th (Check only one)  ome 5 Residence 6 □ Other (Specify)
or Attending Ifter death. Director: After in by the funer	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined 28a. Date of Injury (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)  28b. Time (Month, Day, Year)  28b. Time (Injury)  28b. Time (Injury)  28c. Place of Injury (At home, farm, so building, etc. (Specify))	/ Work? M 1 □Yes 2 □No	<ul><li>28d. Describe how injury occurred</li><li>28f. Location (Street and Number or Rural Route Number, City or Town, State)</li></ul>
e nospital 24 hours a e Funeral t	<u>a</u>	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.		
withir To th comp	Me	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type 231. Date filed (Month, Day, Year)  FFR 1 2 2009	29c. License number	29d. Date signed (Month, Day, Year) 2196. Date signed (Month, Day, Year)
V		30. Name and address of person who completed dause of death (Item 23a) (Type 12 Men W 12)	e, Print) Per PD SiE	5 Citosanaun, MD 216
Sta Regist	ate rar	FFR 1 2 2009 Section D. Again	Made	

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

			1- For Amend Item Sight of Manyland Sept	estynentod Health and Me entificate of Death	ental Hygieng	
	Physici	an	1. Decedent's Name (First, Middle, Last) Starlin T. Watson	2	2. Date of Death Month Da	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Genesis Cromwell; 8710 Einge Rd.	4b. City, Town, or Location of Death Baltimore, MD	4c	County of Death Baltiwore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		B. Date of Birth (Month, Day, Year) Apr 25, 19	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28e-f show any injury or other treumatic event, the Madical Examination and be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  MD Baltimore Bal  10e. Street and Number  8710 Emge Road  11. Marital Status unk 12. Was Decedent Ever in U.S.unk 13. Armed Forces? 1   Yes 2   No   If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) unk  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, Print)  19b. Mai  Genesis Cromwell Nursing Ctr  20a. Method of Disposition 20b. Place 20b. Pl	Ocation  Ltimore  10f. Zip Code  21234  Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri III Yes 2 No Specify:  Bedent's Usual Occupation Be kind of work done during most of working DO NOT use retired)  unk  18. Mother's Name (  ing Address (Street and Number or Rural)  O Emge Road Baltimo	10g. Cit  Unity Yes or No- ican, etc.)  unit 16b. K  (First, Middle, Maider  Route Number, City of	10d, Inside City Limits  1 Yes 2 No  1 Yes 2 No  14. Race - American Indian, Black, White, etc.  Specify: black  ind of Business/Industry un  a Sumame) unk
	Physician /Medical Examiner	edical Examiner				Approximate Interval Between Onset and Death 3 Weeks
P.O. Box	t the death certif by the attending ached for use a:	by Physician/Med		□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23e. Did tobacco	23d. Date of delivery  Month Day Year  use contribute to the cause of death?  □ No 3 □ Probably 4★Unknown
tai Recorc		e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Records,	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Certification; To B	examiner?  1  Yes No Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death Natural 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be determined.	ont 3 DOA Other: 4 Nursing Homorof 28c. Injury at Work?  M 1 Yes 2 No	e 5 Residence  Bd. Describe how inju  Bf. Location (Street a.)	ry occurred  nd Number or Rural Route Number,
Ω	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical Certi	29a. Certifier  (Check only one)  Durse Pract Howet  29a. Certifier  (Check only one)  Durse Pract Howet  Security building, etc. (Specify)  Durse Pract Howet  No the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, ar		) and manner as stated.
ŀ	To the within To the comple	Med	29b. Signature and title of certifier Barbara J. McClaskey, CRN F	29c. License number R 0 3 5 8 9 4		ite signed (Month, Day, Year)
_			30. Name and address of person who completed cause of death (Item 23a) (Type Barbara J, McCleskey, CRDP, 87)	10 Emge Rd; Balt	more in	PEGIC .
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	es .		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			4	rtificate of Death	Reg.	2003	04155
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
~	/Medic		LOUISE M. WEAVER		FEBRUARY	7, 2009	6:46 A M
1	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		SOUTHERN MARYLAND HOSPITAL   5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	CLINTON If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	PRINCE GE	
	Director		244-20-8053 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye MARCH 4,		ace (State or Foreign try)
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation		11	Od. Inside City Limits
	Many	햦	MD PRINCE GEORGE'S CAPITOL	HEIGHTS			1 <b>X</b> Yes 2□No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
	ath wi	rall	6804 DRY LOG STREET	20743	US.	A	
	ltems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, a	
5-0036	Viithin 72 hours after death with the Maryland glene than "natural", or Items 23a or 23a-f show the Madical Examiner mest be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No 3 ሺ Wildowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BLA	.CK
ည်	72 ho 'natur	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	ina 16b	. Kind of Business/inc	ustry
2	e filed within 7 al Hygiene. : other than "r vent, Ihe Med	ldu	Elementary/Secondary (0-12)   College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	}	OME	
ס	it the	ပိ	17. Father's Name (First, Middle, Last)	MAKER  18. Mother's Name	e (First, Middle, Maio	ONE den Surname)	
land	ould be a Mental arked o atic eve	To Be	HENRY DANIELS	ALICE C	HADWICK		
Mary	2 should be and Menta is marked raumatic ev	_	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Run	al Route Number, Cit	ty or Town, State, Zip	Code)
e, E	and 2 lealth m 27 her tr				APITOL HE		20743
0	iges 1 If ite or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposemetery, cre	osition (Name of matory or other place)	Date 20c.	. Location - City or To	wn, State
altim	lit. Pa trimer ritant: njury		4 □ Donation 5 □ Other (Specify) FT LINCOI			RENTWOOD,	
מ	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic evonce.		DONALD R. GRAY	<ol> <li>Name and Address of Facility MAR</li> <li>4308 SUITLAND RO</li> </ol>		UNERAL HOM LAND, MD	20746
			23a. Part 1/Enter the disease, or complications that caused the death. Do not en			Elito, III	Approximate Interval Between
F	Physician		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	e Heart	FALLUX		Onset and Death
	/Medical		resulting in death)  a.  Due to (or as a consequence of):	17001	(6114)		
ľ	Examiner	7	Sequentially list conditions,				
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Eme Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			- 2	
ĵ.	an and rial-tra	Exa	resulting in death) Last C. Due to (or as a consequence of):				
00/00,	rifficate be executed ng physician and as the burial-transit	Medical	d				
Ď :	ding p	/Мес	IF FEMALE:				
ב ב	atten for us	cian		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ry Day Year
<b>.</b>	w requires that the dispersion is been signed by the should be detached	Physician/	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Totter (Specify)			
'n.	gned gned se det	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
ecolds,	een si ould b	ted	Kenel tellure		1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
ב ב	has b	Completed	CORUNARY ANTENY Dise	2 66	24a. Was an autopsy	prior to cor	esy findings available of
יונמי	ong Pnysician; The law n. After this certificate has funeral director, page 2 s	_	<u>'</u>		performed 1 □ Yes 2 ☑	death? No 1 ☐ Yes	2 ⊉No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sicial s certii irecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ ¥0 Hospital: 1 ☐ Impatient 2 ☐ FB/Outpatient	044	(Check only one)		
5 8	g rny er this	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of	f 28c. Injury at	me 5   Residence 28d. Describe how in	6 ☐Other (Specify	)
5 5	ath. or: Aff	atio	2 Accident investigation	Work? M 1 □ Yes 2 □ No			
31717	To the nospina or Attending Priystcian; The law requires that the death ce within 24 hours after death.  To the Funeral Directors. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
<u>.</u> ا	ours a		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	and due to the cause	n(c) and manner as of	atod
i i	n 24 h le Fur	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	evestigation, in my opinion, death occurr	red at the time, date	and place, and due to	the cause(s)
Ė	To the company of the	×	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)
		1	110 Tills Ms	D19889	0	2-08-0	9
1	5 1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	Ci	. ^	3.0
	Stat	te	Date filed (Month, Day, Year)  32 Registrar's Signature	Southern Ave	SE D	C 200	32
	Registra		EER 1 22009 Certain B. Sa	wed .			

				Please	e Type or Prir							-		Legible.		
			For State		State of Ma	aryland ,	•				and Me	ental Hy		0000	01.1	56
			Registrar  1. Decedent's Name	/Eint Middle I	(oot)		Cer	titicat	e or i	Death		2. Date of De		2009	3. Time of I	J O Death
	Physici		2 May 1	- i E	W	1150	(~)				i	Month	Day	Year کنون		
1	/Medic Examin		4a. Facility Name (If	not institution, g	give street and number)			4b. City,	Town, or	r Location o				County of Dea		
					CTIC CENTE					LTIMO						
Н	Funeral		5. Social Security Nu	1	Sex 7. Ag	e (In yrs. last	t birthday). Yrs.	Months	r 1 Year Days	If Under	Min.	8. Date of Bi (Month, D <b>06–07</b> ·	ay, Year)	9. Bi	rthplace (State or Country)  NC	Foreign
	Director		219-20-92 Usual Residence of I		0.							00 07	1723		· · · · · · · · · · · · · · · · · · ·	
	arylan show d at	_	10a. State	10b. County		10c. City, T		cation 'TMOR	E						10d. Inside City	
	the M. 28a-f notifie	ecto	10e. Street and Num	ber			Ditto	10f. Zi					10g. Citi	zen of What C		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Director	5136 WOO		1			1	1215					บร	A	
	ems 2	ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13.	Nas Dece f Yes, spe	dent of H	lispanic Oni	igin? (Spec	cify Yes or N lican, etc.)	0-	14. Race - Am Black, Wh	erican Indian, ite. etc.	
36	s after ; or its	by Fu	1 Never Marrie	_	1 ☐ Yes 2 🛣	No	1	1 □ Yes		Specify:				Specify:	BLACK	
21215-0036	hour tural	ed b		15. Decedent's	Year or Dates:	1	 16a. Deced	dent's Usu	ial Occup	ation			16b. Ki	nd of Busines	s/Industry	
215	hin 72 e. an "ng Medk	Completed	(Special Control of Co		grade completed) College (1-4or	5+)	(Give life. L	kind of wo DO NOT u	ork done ( ise retired	during mos d)	t of workin	g				
	ed wil ygien ner th	Con			2		SI	JPERV	ISOR		r'a Nama	(First, Middle		ONDON E	OG	
and	t be fill he di he	To Be	17. Father's Name (I	FIIST, MIGGIE, LA RVIS	ist)						UCY		NER	ourname)		
Maryland	shoulk nd Me mark umatio	ř	19a. Informant's Na		(Type. Print)		19b. Mailir	ng Addres	s (Street			Route Num	ber, City o	r Town, State,	Zip Code)	
	and 2 salth a n 27 Is er tra		HERMAN PI	URVIS.	SR./SON					GNES	LANE	BALT	0., 1	1D 2120	)7	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Dispo	osition	Removal from State	cem	ce of Dispo netery, crer			· · · · · · · · · · · · · · · · · · ·		ate		_	or Town, State	
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Bal	permi Depar Impo any Ir		21. Signatura d	MISO CITAL SERVICE LIC	a. What	un	-							E, MD 2		1110
	Physician /Medical Examiner		shock, or hear Immediate Cause (f disease or condition resulting in death)	t failure. List or Final 1	omplications that cause only one cause on each !  a.  Due to (or as	ne.	1025							ENTIA	Approximate Interval Betw Onset and D	veen leath
	<b>p</b> .≡	ner	Sequentially list cor cause. Enter Under	martinto.		a consequer	nce of):									
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89	tificate ng phy as the	ledic			4.											
P.O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal de	eath 3[	∃Ectopic p ∃Other (s		у				23d. Date of d Month	,	'ear
	ires that signed b		Part II. Other signifi	icant condition	s contributing to death t	out not resulting	ng in the u	nderlying	cause giv	en in Part I	l.				to the cause of de	
Records,	> 0 0	Completed by										24a. Wa			autopsy findings a	
Re	The la	ошо										aut per 1∏ Yes	opsy formed? 2 No	prior to death	o completion of ca ?	use of
Vital	ilan: ertifica ctor, p	Be C	25. Was case referrexaminer?	red to medical						26. Place	e of Death	(Check only				
or V	ding Physician: The lav n. n. After this certificate has funeral director, page 2.	P	1 ☐ Yes 2 ☐			ent 2 EF				4 PINI				6 □Other (Sp	pecify)	
o uc	ding F	ion:	27. Manner of Death	n 5	28a. Date of Inj (Month, Date)	ay Year)	8b. Time o Injury	M	28c. Injur Wor 1 □	ry at rk?  Yes 2 □		8d. Describe	e now injui	y occurred		
Division	Atten r deatl ector: by the	Medical Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	t be 28e Place of in	jury - At homo tc. <i>(Specify)</i>	e, farm, str					8f. Location City or To	(Street an own, State	nd Number or .	Rural Route Numi	ber,
	Hospital or 24 hours afte Funeral Dir etely filled in	dical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis and manner s	of examination	edge, deat on and/or in	h occurre vestigatio	d at the ti	ime, date a opinion, de	nd place, a ath occurre	and due to the	e cause(s e, date and	) and manner d place, and d	as stated. ue to the cause(s	)
	To the within To the comple	Me	29b. Signature and					-		se number					nth, Day, Year)	
			1	Per A	TONISING	PHYS	ICIAN	2	Do	0649	533.		02	1001	2009	
1			0	1 .	ho completed cause of	death (Item 2	(Type,	Print) L	EVI	VOAL	E G	CHLIATI	DIC.	CIR	MD 212	16
1	)	ate	31. Date filed (Mont	th, Day, Year)		rar's Signatur		557	~ (-1)	i chee	. 146	IANG I	ון ושדוכ	VC112 C	1117 212	
	Regist			EB 122		-	L.		,							

09-01101 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Betty Lee Walker 2009 04157 1. For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1340 hrs **Medical Examiner** February 6, 2009 Betty Lee Walker 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel 1752 Albermarle Drive Date of Birth (MM/DD/YYY Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 6 Sex Country' Months Days Hours Min Director 06/18/1936 73 Mississippi 217-52-4902 M 2X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 X Yes 2 No 28a-f show Crofton MD Anne Arundel with the Maryfand Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 21114 U.S.A. 1752 Albermarle Drive 23a 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death v Armed Forces? 1 Never Married 2 Married 2 X No Yes or White Yes 2 X No specify: 4 X Divorced Yes, Give Year Specify Widowed "natural" ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed pemit: Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Elementary School Teacher Education 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Reynolds Long JD Lee Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O.Box 1682, Valrico, FL 33595 Darryl Lee Walker/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 02/11/2009 Hanover, Maryland Ardent Cremation Services Donation 5 Other Specify 22. Name and Address of Facility 21. Signa are of Funer Service Licensee Ardent Cremation Services 7522 Connelley Drive, Ste.n, Hanover, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Madea Death a. Intracerebral Hemorrhage Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and The law requires that the death certificate be executed Physician/Medical AMENDED attending physician or use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) s been signed by the attraction should be detached for 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of certificate has death? Yes 2 ✓ Yes the Hospital or Attending Physician: thin 24 hours after death.
The Funeral Director: After this certificalled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medica Be Other<sub>4</sub> examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 ✓ Yes ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 V Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

\_\_\_\_\_\_State Registrar

32. Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 7, 2009

Melissa Brassell, MD

31. Date filed (Month, Day, Year) FFB 1 2 2009

30. Name and address of person who completed cause of death (Item 23a)

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Clifford White February 2009 6:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) 07/25/1926 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Days Maryland 217-20-2459 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he confident 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 24 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6601 Charles Way 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify: \$ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Surveyor Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John H. White Mary Grace Collier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 Long Green Rd., Glen Arm, MD <u>Judy Young/Daughter</u> 21057 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State |Anatomy Gifts Registry 02/11/2009 | Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive, STe.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROSTATI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) ned by the a o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, sign. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : autopsy 1 🗆 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPLCE 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 M Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 5 Pending investigation Injury 1 □Yes 2 □No within 24 hours after deatl To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide filled 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ison town 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day q . Month 2009 tebruar trances 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) n/a **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Nov. 22, 1926 If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 5. Social Security Number 212 26 1739 Months Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Baltimore n/a MD Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21213 1237 N. Ellwood Ave. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: black 1 Yes 2X No 3 ₩ Widowed 4 Divorced þ 16b. Kind of Business/Industry Baltimore City Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) public Schools Elementary/Secondary (0-12) College (1-4 or 5+) Food Server 18. Mother's Name (First, Middle, Maiden Surname) Sadie Eggleston 17. Father's Name (First, Middle, Last) Be Joseph Arvin ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1237 N. Ellwood Ave. Balto, Md. 21213 Wanda Walton Jackson (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St Donation 5 Other (Specify) Cemetery Feb. 13, 2009 Baltimore, Md. Oaklawn ature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto,Md. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heart Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examiner ancreatitis resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tyes 2 No 3 Probably 4 🗌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme med 2 No 2 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient မ

**Examiner** or Attending Physician; The law requires that the death certificate be executed physician and is the burial-trans Division of Vital Records, P.O. Box 68760. the al ģ certificate this filled in by the funeral Director: After death. 24 hours a Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

"natural", or items 23a or 28a-f sho dical Examiner must be notified at

the Medical

other traumatic

death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

nd Mental Hygiene. marked other than

of Health a

rtment of h ö permit. Page Department Important: If any injury o

**Physician** /Medical

Baltimore, Maryland 21215-0036

28d. Describe how injury occurred 27. Mayner of Death 1 V Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Injury 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one)

29b. Signature and title of

29c, License number Kes-000 29d. Date signed (Month, Day, Year)

ho completed cause of death (Item 23a) (Type, Print) person es

and manner stated.

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Certification:

Medical

Month, Day, Year)

32. Registrar's Signature

within 2 the

è

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death January 28, 2009 9:05 4b. City, Town, or Location of Death 4c. County of Death Charles LaPlata If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Months Days Hours North Dakota 24, 1917 Aug. 10c. City, Town or Location 10d. Inside City Limits 1t Yes 2 □ No Indian Head 10f. Zip Code 10g. Citizen of What Country? 20640 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1∐Yes 2∏XNo Specify. Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Food Service Board of Education 18. Mother's Name (First, Middle, Maiden Surname) Dora Amelia Hendricson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38994 Bellevue Lane, Mechanicsville, Md. 20659 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State Date 2009 Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility.
Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the Idle ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart to lure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery 3 Ectopic pregnancy Month Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available

				autopsy performed2 1 □ Yes 2 No	prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of Dea	th (Check only one)	######################################
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆	DOA Other: 4 Nursing H	lome 5 Residence 6	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred /
3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a, Certifier 1 Certifying Ph	vsician: To the best of my kno	wledge, death occurre	ed at the time, date and place	and due to the cause(s)	and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and

29d. Date signed (Month, Day, Year)

ted cause of death (Item 23a) (Type, Print)

DOOG1652 | 1 29 2009 #6 Post Office Rd., WALDOR, Md 20602

Registrar

			1 - State Registrar	of Maryland		tificate of		, ,	ene g. No. 2 N N (	01.161
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	200.	3. Time of Death
-	/Medic		Leonard Levi Brown						14 - 2009	
	Examin	er	4a. Facility Name (If not institution, give street and not Washington Adventist Hos			Takoma 1	Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 216-14-514  Usual Residence of Decedent	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7–19–1		rthplace (State or Foreign ountry) ryland
	/land		10a. State 10b. County	10c. City, 1	Town or Loc	ation				10d. Inside City Limits
	a-f sh	ctor	DC	Wash	ingto	n				t★ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23a	eral	4411 19th Street NE	edent Ever in U.S.	140.14	20018	ii- 0-i-t-0 (0-		Jnited Sta	
36	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than Madical Evaninar must be notified at	by Funeral	Armed F	orces? 2 No 1940-	1	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Am Black, Whi	te, etc.
2-0	72 hou natura lical E		15. Decedent's Education (Specify only highest grade completed)	1945	16a Deced	ent's Usual Occup	ation	ina 1	6b. Kind of Business	i/industry
2	ithin 7 ne. han "r	Completed		1-4or 5+)			during most of work			
2	filed w Hygie ther t	CO	17. Father's Name (First, Middle, Last)		Assi	stant Pr		e (First, Middle, M	Federal Go	overnment
au	ev d	To Be	Newton Brown				Anna Ho		ardon Garnamo,	
Maryland 21215-0036	alth al 27 Is r trau	-	19a. Informant's Name/Relationship (Type. Print) Olivia Brown/wife		19b. Mailing	g Address (Street 19th Stre	and Number or Rui eet NE Wa	al Route Number, shington	City or Town, State,	Zip Code)
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Plac	ce of Dispos netery, crem	sition (Name of eatory or other place	ee)	Date 2	0c. Location - City or	Town, State
Ē	t. Pages tment of tant: If it		4 ☐ Donation 5 ☐ Other (Specify)	Fort			ery 1-22		centwood M	
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	gfon					n Funeral ood MD 207	
	Physician /Medical		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)  Due to	spiral	ion	101	g, such as cardiac	1 30	st,	Approximate Interval Between Onset and Death
	Examiner			Sopo	Lis	1.500				
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequer	nce of):					
,	execu n and ial-trar	Examiner	that initiated events resulting in death) Last c	(or as a consequer	nce of):					
68760,	tificate be executed g physician and as the burial-transit	edical	d							
	ding place as t		IF FEMALE:							
.O. Box	w requires that the death certific tbeen signed by the attending p should be detached for use as	Physician/N	in the past 12 months?	atcome of pregnanc birth 2□ Fetal de gnant at time of dea nown	eath 3 🗌	Ectopic pregnanc Other (specify)	y		23d. Date of de Month	Day Year
ж, С	s that gned b e deta	by Pr	Part II. Other significant conditions contributing to o	leath but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did toba		o the cause of death?
ğ	equire	ed						1 ☐ Yes	s 2 No 3 □ F	Probably 4 ☐ Unknown
	The larate has	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital	yslcian; is certific director,	Be	25. Was case referred to medical examiner?	^		I Out		h (Check only one	-	
	di Si	-17	1  Yes 2 No Hospital: 1 X  27. Manner of Death 28a, Date	Inpatient 2 EF	R/Outpatient Bb. Time of	3 ☐ DOA Othe	4 Li Nursing no	me 5 Resider	nce 6 Other (Spe	ecify)
ō	Attending Physician: r death. ector: After this certific by the funeral director,	atior		nth, Day, Year)	Injury	Work	Yes 2 □ No	200. Describe nov	injuly occurred	
Division of	al or Atte s after des Il Director ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place	e of Injury - At home ling, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the 2 Medical Examiner: On the and mar	e best of my knowle basis of examination nner stated.	edge, death n and/or inv	occurred at the tir estigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	as stated. e to the cause(s)
_	Vithi To the comp	ž	29b. Signature and title of certifier			29c. Licenso		I	d. Date signed (Mon	th, Day, Year)
	$\alpha$		* Ayene			6.	5 180		01/15	109
2	1+		30. Name and diss of person who completed cau	Koo Cupy	of a	Frint)	5780 Takom	a par	K, M	0
	Sta Registr	_	JAN 2 9 2009	Registrar's Signatur	معر	•		/		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 04162 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death January 22, 2009 **Physician** Louise Graham Brent 1144 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min 90 578-20-3544 Director 09/18/1918 South Carolina Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c City Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at 1 Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 - 47th Street, N.E. 20019 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 1 year Secretary Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Graham Inez Iogan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any injury or other traum Brenda Anyaibe - Daughter 308 - 47th Street, N.E.; Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hills Cemetery 01/29/2009 Suitland, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee Ulman 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complete Heart Block disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, Due to for as a consequence off Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Diabetes physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical The law requires that the death certificate as aftending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√ Unknown should L Completed his certificate has b I director, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy 1 □Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending after death.

I Director: Ald in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident in 24 hour.
the Funeral Direc. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD32641 January 26, 2009 assatormans no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Assatowians, MD Prince George's Hospital; Cheverly, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 2009 ar **Physician** Jan. 24, 6:30pm M A. Bradley David /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG 811 Falcon Dr. Upper Marlboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 XM 2 ☐ F 93 234-01-1254 Director VA 09-27-1915 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination and injury or other traumatic event, If a Medical Examination and injury or other traumatic event, If a Medical Examination and injury or other traumatic event, If a Medical Examination and injury or other traumatic event, If a Medical Examination and Italian and Ital PG 1X Yes 2 □ No Director MD Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 811 Falcon Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 🎾 No Specify: Black Specify: ģ 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Private Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bransford Flan Bradley Mary ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Bly Ct. Upper Marlboro, MD 20774 Deborah Henderson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem. 1-30-09 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Facility onald Taylor II FH 10583 Middleport Ln. White Plains, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Ye ar 5 Other (specify) ed by the a detached t 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 ☐Yes 2 XNo Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? or Attending 1 Natural
2 Accident 5 ☐ Pending investigation Within 24 hours after usage.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

10

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

State

DHMH 17 Rev 1/2001

Medical

JAN 2 9 2009 Registrar

(Check only one)

29b. Signature and title of certifier

Tin

mant

- 7525 G Greenway 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Weltz

29c. License number

**山23743** 

29d. Date signed (Month, Day, Year)

1-29-2009

Ctr Dr. Greenbett, MD

9-00994 dras Barahona		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No.	1 6
Physicia ledical Examir	ın/	1. Decedent's Name (First, Middle,Last) Edras Noe Agustin Barahona  2. Date of Death Month Day Year February 3, 2009  3. Time of Death 0130 hrs	
		4a. Facility Name (if not institution, give street and number)  Washington Adventist Hospital  4b. City, Town, or Location of Death  Takoma Park  4c. County of Death  Montgomery	
Funeral Director		5. Social Security Number None    6. Sex   1X   M   2   F   F   F   24   Yrs.   1f Under 1 Year   1f Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace (State or Months   Days   Hours   Min.   Dec. 13, 1984   Foreign Guatema.   For	la
Aaryland 28a-f show any 1 at once.	J.	Usual Residence of Decedent  10a. State	
th the Maryland 23a or 28a-f sho notified at once.	1 Director	10e. Street and Number       10f. Zip Code       10g. Citizen of What Country?         7912 15th Avenue       # 302       20783       Guatemala	
after death wir	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Sive Year or Dates: 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify: Guatemalan  White	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours tent of Health and Mental Hygiene. Int! If item 27 is marked other than "unturn other traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  3rd  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Laborer  16b. Kind of Business/Industry  Green Link	
nore, MD 21215-0036  ages I and 2 should be filed within 72  nt of Health and Menial Hygiene.  It l'item 27 is marked other than " other traumatic event, the Medical	8	17. Father's Name (First, Middle, Last)  Miguel Angel Agustin  18. Mother's Name (First, Middle, Maiden Surname)  Fenilia Barahona Lemus	
MD 2 and 2 should saith and M em 27 is ma	٥	19a. Informant's Name/Relationship (Type, Print)	
Internal Co.		1 X Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify:  2/13/09 Guatemala  22. Name and Address of Facility W. H. Bacon Funeral Home, Inc.	
Physician /Medical inition / xaminer		ALCohol intoxication and atherosclerotic cardiovascular Due to (or as a consequence of): USease	erval
ed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.  Due to (or as a consequence of):  Due to (or as a consequence of):	
execul an and al - tra		X UNPENDED 23a,27,28a-f, perME, g889 3/16/09 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	IF FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
ires that the de signed by the signed by the libe detached fi	ģ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown	
tal Records, rian: The law requir certificate has been s ector, page 2 should	Completed	24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No 1 ✓ Yes 2 No	of
Division of Vital Records, tal or Attending Physician: The law requirers after death.  In Director: After this certificate has been sited in by the funeral director, page 2 should be a beyond the funeral director, page 2 should be a second to the funeral director.	To Be	25. Was case referred to medical examiner?  1 V Yes 2 No  1 No  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury at Work?  28c. Injury at Work?  28d. Describe how injury occurred	
Division Hospital or Attendi 24 hours after death. Funeral Director:	Certification;	Natural Accident Accident Suicide Homicide  Natural Suicide Accident Suicide Homicide  Natural Suicide Accident	City is
D To the Hospital within 24 hours. To the Funeral completely filled	Medical C	29a. Certifier (Check only 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
3	Me	29b. Signature and title of certifier  29c. License number O.C. M.E.  29d. Date signed (Month, Day, Year) February 3, 2009	
-		30. Name and address of person who completed cause of death (Item 23a)	-

State 31. Date filed (Month, Day, Year) Registrar

111 Penn Street, Baltimore, MD 21201

Theodore M. King, Jr., MD. Assistant Medical Examiner

		Registrar	Ce.	rtificate	OI D	calii			Reg. No.			
Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day		Year	3. Time of Death
/Media	al	Mildred C. Banks		4b. City, To				January		20	09 of Death	1:58 P M
Examin	er	4a. Facility Name (If not institution, give street and number)  Montgomery General Hospital		01ne		LOGATION (	n Death				omery	7
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)	If Under 1	Year	If Under		8. Date of Bir		11108	9. Birthol	lace (State or Foreig
Director		242-24-8519 1 M 2 🕮 84	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 11/8/19	24		NC NC	(ry)
illed within 72 hours after death with the Maryland ther than "natural", or items 23a or 28a-f show int, the the cities Examiner ment be notified at		Usual Residence of Decedent  10a. State 10b. County 10c. City	y, Town or Lo	cation							10	Od. Inside City Limits
pomint. Tagos I and a Should be the whall returned a telephone beauth will the way year began the leading and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinal ment be retified at once.	호	MD Montgomery Sil	ver S	orina								1⊠Yes 2 □ No
r 28a	Director	MD Montgomery Sil	ver b	10f. Zip C	Code				10g. Citi	zen of V	Vhat Count	try?
23a c		1143 Netherlands Court		20	905				US	SA		
tems	Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deceder If Yes, specify	nt of His y Cuban	panic Ori , Mexicar	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	)-		e - America k, White, e	
or i	y F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 [		Specify:				Specify		
atural PE	ed	15. Decedent's Education	16a. Dece	dent's Usual	Occupat	tion			16b. Ki	nd of Bu	siness/Ind	
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d oth even	Be	17. Father's Name (First, Middle, Last)			1			(First, Middle,		Surnam	e)	
narke	ု	Eddie Luther Chavis	1					berta I		_		
7 Is n traun		19a. Informant's Name/Relationship (Type. Print)	1					al Route Numb				code) and 20877
tem 2		Diann E. Waters/Daughter  20a. Method of Disposition 20b. P		sition (Name natory or othe				Date			City or To	
ont of ht; If i				natory or othe ek Cem			1/30	1/2009	Wash	ning	ton,	DC
ortar Injur		21. Signature of Funeral Service Licensee	22	2. Name and	Address	of Facilit	y Mar	shall's				
any ir		P. Marshall	4	217 Ni	nth	Stre	et.	NW Was	shing	gton	, DC	20011
ysician Medical aminer	niner	Imm late Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  a. Due to (or as a consequence of the consequence of the cause).	uence of):	Hem	ori	r he	3	<b>e</b>				Onset and Death
ng physician and as the burial-transit	Medical Examiner	Due to (or as a consequence).	uence of):									
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certificate ha rector, page	Be (	25. Was case referred to medical examiner?					of Deat	Check only o				
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Director; Affer the in by the funeral	Certification: To	27. Manner of Death  1	28b. Time of Injury me, farm, str	М		at es 2□	No	28d. Describe I 28f. Location ( City or Tou	Street an	d Numb		l Route Number,
Funeral tely fillec	Medical Co	29a. Certifier (Check only one)  Certifying Physician: To the best of my knor 2 Medical Examiner: On the basis of examinal and manner stated.	wledge, deat tion and/or in	h occurred at vestigation, in	t the time	e, date ar nion, dea	nd place, ath occur	and due to the red at the time,	cause(s)	and ma	nner as st	tated. the cause(s)
<b>To the</b> comple	Me	29b. Signature and title of certifier			License	number	98	1		-	( Month, L	
		30. Name and address of person who completed cause of death (Item Mukenil Phole II.a., m.	<b>n</b> 1	Print)						ney,		20832
		31. Date filed (Month, Day, Year)  JAN 29 2009  JAN 29 2009  JAN 29 2009										

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Barbara Ann Bright Jan. 17 2009 7:35a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5713 Sora Lane Riverdale Prince George's Birthplace (State or Foreign Country) Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛣 F 03/08/1936 West Virginia 233-58-4317 72 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No Item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Fedical Examinant the colling Completed by Funeral Director Maryland Prince George's Riverdale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5713 Sora Lane 20737 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛣 No 21215-0036 Specify: Specify: B1ack 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government <u>Administrative Assistant</u> Baltimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Clarence Nathaniel Cosby Arlene Johnson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5713 Sora Lane, Riverdale, MD Monette Green - Daughter 20737 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of F
Important: If Ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 1/24/2009 Ft. Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD Nortabreen 23a. Part 1. E. | r the disclase, x complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rdocras ca disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Registrar's Signature 31. Date filed (Month, Day, State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year MARIE JOSEPHINE BURKE 0855AM Januar 2009 23 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 □ F Yrs. 517-07-7426 89 1919 Montana Dec. 16, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20908 1907 Kimberly Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viggo Sigvardt Ida Svendsen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael R. Warner-Burke / Son 6274 Gay Topaz, Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Wash. Mem. Park 2/2/09 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland 21. Signature of Funeral 3 rvive License ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Arkenter 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Responder AL W. or resulting in death) Due to (or as a consequence of): R Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Rhobda Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗆 140 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

physician and the burial-tran

attending p as

by the a

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nis certificate has director, page 2

this funeral

After

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neral Director: Af
filled in by the fur

24 hours

within 24 hou

To the Fune

completely fill

Medical

Physician

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

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**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "socieal Examinat Issuet be notified at once.

Baltimore, Maryland 21215-0036

Examiner Be

Physician/Medical Completed by Certification: To

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? I ☐Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 4No 27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

1 Tripatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier COUT MD

29a. Certifier

(Check only one)

29c. License number D18019 29d. Date signed (Month, Day, Year) 24,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILL ST HACER FROWN MOZINGS VASKNT DATTA MD 3 Wu

and manner stated.

State Registrar

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31. Date filed (Month, Day, Year) JAN 29 32. Registrar's Signature

oarked.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2009 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day George Melvin Beavers 26**,** 2009 5:09 p January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George 7. Age (In yrs. last birthday)

R3 Yrs. | Months | Days | Hours | Min. | July 5, 6. Sex **X** M 2 □ F Birthplace (State or Foreign
Country) 5. Social Security Number <sup>Year)</sup> 1925 577-24-0676 Washington D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TXNo Maryland Accokeek Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20607 308 Biddle Road U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 XYes 2 No
If Yes, Give 1 Never Married 2 Married 1943-1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Year or Dates: 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, William Beavers Virginia Penn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Biddle Rd., Accokeek, Md. 20607 Shirley M. Beavers Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 4, 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Cheltenham, Maryland 4 Donation 5 Dother (Specify) Maryland Veterans Cemetery 22. Name and Address of Facility
Willaims Funeral Home, 21. Signature of Funeral Service Licen , e M00668 4270 Hawthorne Rd., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Indian Head, Md. 20640 Immediate Cause (Final MEUMONIA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

Director

Funeral

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Completed

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Examiner

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "hadical Exportment myst be notified at

within 72 hours after

Baltimore, Maryland 21215-0036

and -burialphysician the attending p signed by the a has certificate

death certificate be executed Box ( P.0. of Vital Records, al or Attending F after death. I Director: After Division 24 hours a

68760

Physician/Medical þ Completed Be Ė Certification: To this eral Director: After th filled in by the funeral

within 2

Hospital

Registrar

Medical

mosernogi.

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

29c. License number D48158

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9628 Marlbons Pike

Upper MARLBORD

OSIA 31. Date filed (Month, Day, Year)

JAN 2 9 2009

32. Begistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day JOHN ROBERT BOYER JANUARY 29 2009 1:43/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13928 ROCKDALE ROAD CLEAR SPRING WASHINGTON If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Months 1☑M 2□F Hours Director 212-24-7288 Usual Residence of Decedent 1928 MARYLAND permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MARYLAND WASHINGTON CLEAR SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13928 ROCKDALE ROAD <u> 21722</u> U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No 1952— If Yes, Give Year or Dates: 1954 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced 1954 WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNED & OPERATED INSURANCE AGENCY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ JOHN LEWIS BOYER ALTA MAY LAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH BOYER/SPOUSE 3928 ROCKDALE ROAD, CLEAR SPRING, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) MT. OLIVET CEMETERY Feb. 3, 2009 | FREDERICK, MARYLAND 21. Sign ature of 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME Paul M. Dean 7606 Old National Pike, Boonsboro, MD 23a. Parti. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) X415 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No Was a.. autopsy performed? Yes 25 No 1□ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes Hospital: 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

FEB n 2. 2009

31. Date filed (Month, Day, Year)

Mary E. Money

32. Registrar's Signature

354

MO

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

023815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month January 20, 2009 **Physician** Marie Olivia Corbin 1138 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clintan  $\mathbf{FG}$ If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 75 579-40-7983 Director 08/24/1933 Washington, M Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be mailined at MD RG Capitol Heights 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 409 Clovis Avenue 20743 USA Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Ite ury or other traumatic event, Item Medical Event in Item 17 is marked other than 17 is marked other than 17 is marked or other than 18 is marked or 1 □Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Danestic Self 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ollie John Smith Dorothy Smith (Green) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Conduita Corbin Nicks - Daughter 409 Clovis Avenue; Capitol Hgts, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Its any Injury or o 1. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/03/2009 Triangle, Virginia Quantico Nat. Cem. 22. Name and Address of Facility Freeman Funeral Services 21. Sign wife of Funeral Service Licenses ndano 4594 Beech Road; Temple Hills, Maryland 20748 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ cate has been signage 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 ☑No 1 🗆 Yes 2 1100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **⊋**∕Ño 2 ER/Outpatient 3 DOA N☐ Inpatient Certification: To funeral 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pt24 hours after death.Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title Jan 20m

State

31. Date filed (Month, Day, Year)

JAN 2 9 2009

hard talmen up 1328 Southern avenue Sq

an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Sucte 310

10055120

Washington DC 20032

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY **Physician** 5:22 P M RAYMOND CONWAY JR. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 1 HIGH HAVEN PLACE # TB NOTTINGHAM 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**∑** M 2□ F Yrs. Director APRIL 17 1956 NEW YORK 094-46-3722 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits al Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner mast be notified at 10b. County 10c. City, Town or Location Y☐Yes 2☐No Director NOTTINGHAM MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number # 1 HIGH HAVEN PLACE TBUSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: \$ BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked o permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev RAYMOND A. CONWAY SR. HESTER WOODS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN HOKETT-CONWAY/WIFE 6117 SILVER LEAF LANE DISTRICT HEIGHTS, MARYLAND 2074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5☐Other (Specify) HARMONY CEMETERY 1/24/2009 LANDOVER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, ol complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SUBARCHNOIDAL BLEED /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to minimaliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to (or as a consequence of) law requires that the death certificate be executed signed by the attending physician and defacthed for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð THYMOMA IN REMISSION 2√ No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should GRAVIS 24b. Were autopsy findings available prior to completion of cause of death? MYASTHENIA 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 😾 No OSTEOMYELITIS 1 ☐ Yes 2 ₽No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: To the Hosp.....
within 24 hours after dearn.
To the Funeral Director: After this c 1∏Yes 2∏No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. Date signed (Month, Day, Year) 29b. Signati RASOC. 29c. License number . Meg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETR HAUSNER M.D. 22 SOUTH GREENE STREET BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 2009 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CLARK **JANUARY** 2009 11:45 JANETTA MARY 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CHEVERLY PRINCE GEROGE'S HOSPITAL PRINCE GEROGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕏 F Months Days Hours Min 50 Director SEPT 25 1958 MARYLAND 577-78-8953 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location show in than "natural", or Items 23a or 28a-f sho 1X Yes 2 No Director MD PRINCE GEROGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6703 ASSET DRIVE 20785 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) YRS CLERK GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUTH CHAPMAN 7 is marked traumatic e JOSEPH CLARK ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 is 6703 ASSET DRIVE LANDOVER, MARYLAND 20785 SHA-RON CLARK/DAUGHTER Department of Heal Important: If item 2 any injury or other or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 2/3/2009 LANDOVER, MARYLAND 5 Other (Specify) HARMONY CEMETERY 21. Signature of Fun 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Service License 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) ARDIAC FATAL **Physician** /Medical Due to (or as a consequence of): ARDIC MYC PATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify)

**Examiner** The law requires that the death certificate be executed physician and s the burial-transit Box 68760, attending pl Ö cate has been signed by the page 2 should be detached Division of Vital Records, P. tal or Attending Physician: Tis after death.

al Director: After this certificate led in by the funeral director, pa Hospital

death

filed within 72 hours after

Mental

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral Completely filled State Registrar 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 HOSPITAL

BERHANE MD 1310N 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 28, 2009 **Physician** 12:13A. M Cullins William Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. Avenue, Maryland Jűne10, 1919 1**∑** M 2□ F 89 577-38-7461 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 United States 3122 Gracefield Road, CC414 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 □Yes 2 No Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic event, the Ma Elementary/Secondary (9-12) College (1-4or 5+) Model Maker Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Dingy John A. Cullins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3122 Gracefield Road, CC414 Silver Spring, Md.20904 Margaret Cullins -wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 1/28/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran and Due to (or as a consequence of): attending physician for use as the burial The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Dementia; Parkinson's Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? yes 2**X** No certificate 2 🕅 No 1 □Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one)

P.O. Box 68760, Division of Vital Records, To To the Hospital or Attending Physician: a within 24 hours after death.

To The Funeral Director: After this certification pletely filled in by the funeral director, p

> Loveen Puthumana, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 29 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated.

humans

29c. License number

D59524

29d. Date signed (Month, Day, Year)

January 26, 2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** January 22, 2009 16:25 DAVID RALPH CONNERS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Laurel Regional Hospital Prince George's Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT | 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral ™** M 2□ F Months Days Wisconsin 395-22-7264 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment Librar to restrict 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 1 ☐Yes 2√∑ No Funeral Director Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13220 Ronehill Drive 20705 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

| XYes 2 No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Norean Conflict 1 □ Yes 1 No Year or Date one On I lict Specify White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Job Classifier D.C. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William R. Conners Florence Lepke 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy J. Conners -wite 13220 Ronehill Drive Beltsville, Maryland 20705 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State George Washington Cemetery 1/27/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA evel 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Aspiration Pneumonia resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia; Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🖾 No 2 XNo 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∐XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Myllille MD D64760 January 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mythily Vancha, M.D. 10724 Little Patuxent Pkwy., #200 Columbia, Maryland 21044 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Year **Physician** 08:30 AM Januar 200 ONAL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and nymber) 4b. City Town, or Location of Death Examiner WOSTINGEN Vear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV. 17,1924 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 XM 2 □ F Months Days Maryland 84 Director 218-16-3563 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Exacting quantity and perceptified at 1X Yes 2 □ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ö 23a 21740 USA 124 Rav Street Funeral death v items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or ites 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo ò If Yes, Give Year or Dates: Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Maintenace WOrker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Robert J. Case Margaret Beaman 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
124 Ray Street
Hagerstown, MD 21740 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trau Virginia Case/Wife 20b. Place of Disposition (Name of cemetery crematory or other place)
Howard University
Medical School 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/09 Washington, DC 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Austin Royster Funeral Home DC 20011 3821 14th Street, NW, Washington, 23a. Part : Eyer the disease, or complications that caused the death. Do not enter the months of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death in of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medica! Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner ending physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death The law requires that the death 3 Ectopic pregnancy ò Month Year signed by the a 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy this certificate 2 No 1 ☐ Yes 1 □ Yes Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 2) Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 5 Pending investigation e Hospital or Attendii 24 hours after death. e Funeral Director: A letely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARONIVE 315 PNI 31. Date filed (Month, Day, 3 Registrar's Signature Year) State 29 JAN Registrar

State of Maryland / Department of Health and Mental Hygiene 1 \_ For State

			1 - For State Registrar		•	rtificate of		Re	eg. No 2009	04176
	Physicia	an	1. Decedent's Name (First, Middle, Last		E LOUISE	CONNORS		2. Date of Deat Month January	Day Yea	3. Time of Death 4:45 P M
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of De	ath
ľ			Glade Valley Nursi 5. Social Security Number 6. Se		Ctr.	Walkers	sville If Under 24 Hrs.	8. Date of Birth	Freder	irthnlace /State or Foreign
	Funeral Director			M 2√ F /	89 Yrs.	Months Days	Hours Min.	Dec. 15,	<sup>Year)</sup> 1919 Ca	Country) Lifornia
	land bw it		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary	ctor	Maryland Frederic	:k	Frederic	k				1 ☐ Yes 2 ☐ No
	with th	Funeral Director	10e. Street and Number 6129 Fieldcrest Dr	ive		10f. Zip Code 2170	01	11	0g. Citizen of What (  U.S.A	*
	death	ınera	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- po Rican, etc.)		nerican Indian,
20	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Instred other than "natural", or items 23a or 23a-f show larked other, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No			Specific	White
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7	filed within Hygiene. ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Portrai	-		Art	
yland	be filed ntal Hyg of othe event,	Be	17. Father's Name (First, Middle, Last) Bertie Parkhurst					e (First, Middle, M	•	
	should be filed wind Mental Hygies marked other tumatic event, th	ျ	19a. Informant's Name/Relationship (T)	ype. Print)	19b. Maili	ng Address (Street			, City or Town, State	, Zip Code)
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nore	ages 1 ar		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	-	osition (Name of matory or other place org Cremat			20c. Location - City o	or Town, State , Maryland
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	e a E c		23a Part1 Enfer the disease or coom	lications that caused the	12	01 NORTH	MARKET S	TREET F	REDERICK	MD 21701 Approximate
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	a CORO		HEND		ISE AS		Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a co		1121	-1 ()	1012.113		207.0
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л Э	requires that the neen signed by the		9 ☐ Unknown  Part II. Other significant conditions of	9□ Unknown	ot resulting in the u	ınderlying cause giy	ren in Part I	23e Did tob	pacco use contribute	to the cause of death?
cords,	quires t n signe uld be o	d by								Probably 4 🗹 nknown
Φ	law re as bee	Completed						24a. Was ar	y prior t	autopsy findings available c completion of cause of
VII all K	iclan: The law certificate has t ector, page 2 s		25. Was case referred to medical				26 Place of Dog	perforr 1  Yes 2 th (Check only on	2 <del>1</del> √0   1 □ Y0	
or vi	S σ = Ξ	To Be	examiner?		2 ☐ ER/Outpatie		er: 4 Nursing H		ence 6 □Other (Sp	pecify)
	ding n. After fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wor	ryat k? Yes 2 ∐No	28d. Describe ho	w injury occurred	
UIVISION	pital or Attending ours after death. teral Director: After filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, st Specify)	reet, factory, office	-	28f. Location (St. City or Town		Rural Route Number,
2	spital o		29a. Certifier 1 CertifyIng Phy	ysician: To the best of m	y knowledge, dea	th occurred at the ti	me, date and place	e, and due to the ca	ause(s) and manner	as stated.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated	amination and/or ir	nvestigation, in my	opinion, death occu	irred at the time, d	ate and place, and d	ue to the cause(s)
	To with	2	29b. Signature and title of certifler  Divide using	MD		29c. Licens	21936	2	9d. Date signed (Mo	
•	(2)		30. Name and address of person who o	completed cause of death	(Item 23a) (Type			1 7.0		ICK 21702
	Sta	ate	31. Date filed (Month, Day, Year)	NEUSIN MI 32. Registrar's	Signature	1 mmas	JOHN 301	UDE	TREVER	11 21/04
	Regist		JAN 29 2	2009 Denesea	a B. x	parker				

			For State Registrar	State of Marylar	id / Depa <i>Ce</i>	artment of F <i>rtificate of I</i>	lealth and Death	d Mental Hy	rgiene 0	09	04177
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	Funeral Director		5. Social Security Number 6. 5	Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F	7 1 Yrs.	Months Days	If Under 24 F Hours M	lin. 8. Date of Bi (Month, D MAY 2	ay, Year)	Coun	place (State or Foreign ortry) SHINGTON
	σ		Usual Residence of Decedent  10a. State 10b. County	100 0	ty, Town or Le	ocation		12212	0, 100		Od. Inside City Limits
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	r 28a	irec	10e. Street and Number	WA	OIIIII	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	ath wit	ral	351 Chaplin St				019				States
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ampringing or other traumatic event, Item and call a natural perposition at an ange.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	l.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ▼No	lispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes or No uerto Rican, etc.)	o- 14, Ra Bla Specii	ce - Americ ack, White, e	
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	Physician		23a. P. rt 1. Enter the dise se, ir con ock, or heart failure. If st only Immediate Cause (Final			uce	119, 00011 00 001	and or respiratory	arroot,	1	Interval Between Onset and Death
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	t the deat by the att ached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of		Other (specify)			M	lonth	Day Year
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/Ital	sician: certifica irector, p	Be C	25. Was case referred to medical examiner?			Tau		Death (Check only			
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DIVISION	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fur	Certification:	3 Suicide 6 Could not 4 Homicide determine		home, farm, s	treet, factory, office	-	28f. Location City or To	(Street and Num own, State)	ber or Rura	al Route Number,
	ne Hospit n 24 hours ne Funera	Medical (	29a. Certifier Check only one) Certifying F	Physician: To the best of my kr aminer: On the basis of examin and manner stated.	nowledge, dea	ath occurred at the t investigation, in my	ime, date and popinion, death	place, and due to the occurred at the time	ne cause(s) and r e, date and place	nanner as	stated. to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier	Minsal		29c. Licen	se number	G @	29d. Date sign	ed (Month,	Day, Year)
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1	0		30. Name and address of person with	o completed cause of death (Ite 14-7525 GY	ern 23a) (Type	ey Center	Drive,	Greens	elt, MID	ret	70
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature -	N .			ι		

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Gladys Maud Delapenha 26, 2009 9:49A Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Co. Montgomery General Hospital 9. Birthplace (State or Foreign Country)
Kingston, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-11-1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 🔀 F 85 216-59-9767 Director <del>Jamāica</del> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show traumatic event, the Medical Examiner Fust be notified at Director 1 Yes 2 □ No Ashton MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20861 USA 17429 Avenleigh Drive 'natural", or Items 23a Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No **Black** If Yes, Give Specify 2 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs filed withir I Hygiene. Private Industry Administrative Asst. Is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: If Item 27 Is marked other any injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Baker Simon Brown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17429 Avenleigh Drive; Ashton, MD 20861 Robert Delapenha (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐ Removal from State Riverdale Pk Crem 02-04-2009 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Raiph Williams Funeral Service 1813 Potomac Ave., SE; Washington, DC20003 21. Signature of Furneral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** has. /Medical Due to (or as a consequence of) Examiner Heulus is Sequentially list conditions Examine Due to for as a consecutional of if any, leading to introduc cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and burial-trai Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 certificate l 2 No 1 ☐ Yes Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Direct 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie me and address of person who completed cause of death (Item 23a) (Type, Print) Porne Philip Dr. MD 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 6:00 AMM Lessie Davis January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ft. Washington Prince George 7519 Blanford Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🖵 F 97 April 9, 1911 Virginia Director 230-16-5808 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Wedgal Evantion must be notified at 1 ☐ Yes 2 X No Director Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 20744 U.S.A. Funeral 7519 Blanford Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 No Specify: <u>გ</u> 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental I-27 is marked ot traumatic ever Pages 1 and 2 should be Sydnor Jackson Susie B. (Unobtainable) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other train 7519 Blanford Dr., Ft. Washington, MD 20744 Mary Taylor (Niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Buriat 2 ☐ Cremation 3 ☐ Removal from State New Shiloh Cemetery 1/24/09 Nathalie, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Jeffress Funeral & Cremation Lusardi Dr., Brookneal, VA 24528 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4Thenos **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐No 24a Was an certificate 2 No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Address 1 ☐ Yes 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 1/70/ 1ivingston R/ HIOI ff WAshington
MO20746 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SiDAROUS, M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		-	For State Registrar	State of Mai	ryland / I		artment of H <i>rtificate of L</i>		Men	tal Hy	giene Reg. No.	2009	04180
	Physicia	an	1. Decedent's Name (First, Middle,							Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al		ZABETH DAVIS	DRIVE	R	4b. City, Town, or	Location of Doc	<u></u>	JAN	22	2009 County of Death	3:50 A M
	Examin	er	4a. Facility Name (If not institution, INATIONAL NAVA)		NTER			HESDA	uı		40.	MONTGO:	
	uneral Director		5. Social Security Number 413-22-8797	5. Sex 1 □ M 2 🖾 F 87	(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (	Date of Bir Month, Da V • 16	ay, Year)	9. Birth Cou 21 Smitl	place (State or Foreign ntry) hville, TN
land	wo #		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation						10d. Inside City Limits
Mary	a-f sho	tor	Maryland Prince	George's	Distr	ict	Heights						1 X Yes 2 ☐ No
th the	or 28g	Director	10e. Street and Number				10f. Zip Code					zen of What Cou	ntry?
ath w	s 23a	eral	2307 Ramblewood			10.1	20747	lanania Origina (	Cnacifu	Von or No	U.S	A.	on Indian
G Z IZ I 3-0030 filed within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show dical Evenine: must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? d 1 □Yes 2 ☒No If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □Yes 2∑No	Specify:	rto Rica	n, etc.)		Black, White,  Specify: Wh:	etc.
<b>2-0</b>	natura Jical E	Completed	15. Decedent's (Specify only highest	Education grade completed)	168	(Give	dent's Usual Occup	lurina most of wo	orkina			nd of Business/Ir	*
vithin	than "	mple	Elementary/Secondary (0-12)	College (1-4or 5+	·)	`life. L	DO NOT use retired eacher	)			i .	yland Si Educatio	tate Board '
rilled v	Hygie other t		17. Father's Name (First, Middle, La	ast)			acher	18. Mother's Na	me (Fil	rst, Middle			
id be	nked o	To Be	Bruno Davis					Orbie M	lae i	Brent	-		
s shou	and N is mal auma		19a. Informant's Name/Relationshi				ng Address (Street				-		
and	leaith m 27 ther tr		Regina Driver (I	)aughter)			Bicenten		, P	ort F		lic, MD	
altumor	Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the "Next once.	1	20a. Method of Disposition  1X Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	ecify)	1	b Me	sition (Name of matory or other place em. Garden	ns  1/26				thville	
permi ga	Depar Impor any Ir	y is	21. Sign, ture of Funeral Service Li	Vellenn		I 1	2. Name and Address Love-Cant LOO East	rell Fur Church S	t.,	Smit	:hvil	le, TN	
	ysician		23a. Part 1. Enter the disease, or c shock, or heart fallure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line	e. RUPTUR	E O	er the mode of dyir						Approximate Interval Between Onset and Death
	Medical aminer	L	Sequentially list conditions	Due to (or as a									
nted	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):							
<b>58 / 5U,</b> fficate be executed	sician and burial-tra		that initiated events resulting in death) Last	Due to (or as a	consequence	e of):							-
	g phys as the	edical		d									
O. BOX	been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 🗌 Fetal dea		☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у				23d. Date of deli Month	very Day Year
ords, P.O.	n signed by uld be deta	ğ	Part II. Other significant condition	is contributing to death bu	t not resulting	in the u	nderlying cause giv	en in Part I.			tobacco u		the cause of death?
The law	s certificate has bee irector, page 2 sho	Completed								24a. Was auto perf 1 □ Yes	opsy orm <u>ed</u> ?	prior to c	topsy findings available ompletion of cause of
OT VITA Physician:	is certific director,	Be (	25. Was case referred to medical examiner?	Hespital:			Oth	26. Place of D	· ·				
Phys	.≝ <b>P</b>	5.	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1  ☐ Inpatie	nt 2 ER/0	Outpatie		4 LI Nursing				6 ☐Other (Spec	sify)
on ding	ith. :: After th e funeral	tion	1 Natural 5 Pending 2 Accident investigs	(Month, Day	í, Year)	Injury	Wor	ḱ? Yes 2 □ No				,	
DIVISION I or Attending	after dea   <b>Director</b> d in by th	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		iry - At home, c. (Specify)	farm, sti	reet, factory, office		28f.	Location City or To			ral Route Number,
e Hospita	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier Check only one) Certifying 2 Medical E	Physician: To the best of the basis of and manner sta	examination a	ge, deat and/or ir	th occurred at the tinvestigation, in my o	me, date and pla opinion, death oc	ce, and	due to the	e cause(s e, date an	and manner as d place, and due	stated. to the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier	0 0		7	29c. Licens	se number				te signed (Month	
	4		) IUU	V		$\sim$	42636	(MN)			27	当るしい	7-175001
,	12		30. Name and address of person v			a) (Type,	TALL	IONAL NA				CENTER	
	Sta	ate	31. Date filed (Month, Day, Year)	CDR MC US 32. Registra			BET	HESDA MC	20	889-5	0600_		
	Regist		JAN 2 8 2009	Saneur S.	par								

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 25, 2009  $04 \cdot 56$ <u>Malissa</u> Doster Ann January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Funeral Months 281-50-3669 1 □ M 2 🗓 F 59 Yrs. Director April 13, 1949 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a4 show amy injury or other traumatic event, the Incident Exercities to confirm an once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐Yes 2 ☐ No Director Maryland Prince Goerge's Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6007 Terence Drive 20735 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. African 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: Specify: American þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Riley Smith Hattie Macbeth P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Earl Doster - Husband 6007 Terence Drive Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Heritage Memorial Park Jan 31, 2009 Waldorf, MD 21. Sign turn of Euneral Services 22. Name and Address of Facility Stewart Funeral Home, Inc. M. July 4001 Benning Road, NE Washington, DC 20019 23a. Part Uniter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sistem to U **Physician** 42 Krew enythe. disease or condition resulting in death) /Medical Examiner MIKE Emba Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a const quence of): Examiner the death certificate be executed sician and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown atter 3 Ectopic pregnancy for Month Year 5 Other (specify) ö the signed by the 9 Unknown ۵. or Attending Physiclan: The law requires that tafter death. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Š 1 ☐ Yes 2 🟋 No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; of completely filled in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 043446 1.25.09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia An Init 7-32 silver 127 1/2 20902 Roin TAN FARAMIFAR H.D. 32. Registrar's Signature 31. Date filed (Month, Day) State JAN30 2009 Registrar

Certificate of Death

4b. City, Town, or Location of Death

CHEVERLY

Reg. No 20

ĩ948

2009

PRINCE GEORGE'S

HAITI

14. Race - American Indian.

BLACK

20785 Approximate Interval Between Onset and Death

4c. County of Death

USA

PRIVATE

23d. Date of delivery

1 TYes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

09

28d. Describe how injury occurred

20774

Day

24b. Were autopsy findings available prior to completion of cause of death?

2X No

Year

Month

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

14 Yes 2 □ No

3:08 PM

2. Date of Death

JANUARY

Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Ligense number

1 ☐ Yes 2 ☐ No

10062141

DECEMBRE

Division of Vital Records, funeral director, this After t I hours after death. filled in by To the Hospital within 24 hours a To the Funeral I completely

27. Manner of Death

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of

5 | Pending

investigation 6 ☐ Could not be

determined

= State Registrar

**Physician** 

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE'S HOSPITAL

GERARD

Medical Certification: To (6) State Registrar

OLUMIDE A. COKER MD 1221 MERCANTILE LANE LARGO, MARYLAND 31. Date filed (Month, Day, Year, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Mary				lental Hyg	iene				
			State Registrar	Ce	rtificate of	Death	7	eg. No. 2 ()	9 0	4   83		
	Physicia	n	1. Decedent's Name (First, Middle, Last)  Marie Paris Elmo				2. Date of Deat Month	Day Ye	ear	ime of Death		
	/Medic Examin	1.00	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	January	20 20 4c. County of E				
لإح	Examin	er	Sinai Hospital of Baltimore		Baltin			Baltimo	re			
rate (	Funeral		5. Social Security Number 6. Sex 7. Age (II	yrs. last birthday			8. Date of Birth (Month, Day,	9		State or Foreign		
	Director		579-38-3634 1□M 2XF 78	Yrs.			2/11/19	30 DO				
	and w		Usual Residence of Decedent           10a. State         10b. County         10	c. City, Town or L	ocation	·			10d. Ins	side City Limits		
	Mary -f sho	to	DC n/a	Washingt	on				1 [	XYes 2 □ No		
	th the or 28a e noti	irec	10e. Street and Number		10f. Zip Code			0g. Citizen of Wha	,			
	ath wi	ral	226 10th Street, SE		20003			nited Sta				
36	be filed within 72 hours after death with the Maryland ntal Hygiene. Adother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of H If Yes, specify Cubin 1 Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify: Mex		Black, \	American Indi White, etc. Black	lian,		
Maryland 21215-0036	2 hour atural		15. Decedent's Education		edent's Usual Occup			16b. Kind of Busin	ess/Industry			
212	hin 72 e. an "na Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+	life.	e kind of work done DO NOT use retire	during most of worl d)						
21	ed wit	Con		Teacl	her			DC Publi	c Scho	001		
Ind	2 should be filed vand Mental Hygie Is marked other traumatic event, tr	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)				
<u> </u>	s 1 and 2 should be if Health and Mental Item 27 Is marked oother traumatic eve	2	Oliver Wendell Madden  19a. Informant's Name/Relationship (Type. Print)	19h Mail	ing Address (Street	Adie Sel	-	r City or Town Sta	te Zin Code	o)		
Z	D = C =		Maria Triva Elmo / Daughter		lumber, City or Town, State, Zip Code)							
altimore,	s 1 and 2 if Health Item 27 other tra		20a. Method of Disposition	20b. Place of Disp		1		20c. Location - Cit	y or Town, St	tate		
E	Pages nent of ant: If its ary or o		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		National		2009	Triangle	, VA			
Balti	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other		21. Signature of Fluneral Service Licensee		22. Name and Addre							
b	- 53		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Appro	oximate val Between		
1838 E	Physician	î j	Immediate Cause (Final disease or condition	cardial	Infarctio	n			Onse	et and Death		
1.	/Medical Examiner		Due to (or at a co	onsequence of):								
	Lammer	10	Sequentially list conditions, b. Due to (or as 1.0	our tension onsequence of):	~				_			
0	nsit	nine	if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events  c.	orisequence ory.					Ĩ			
D,	execuna and ial-tra	Examiner	resulting in death) Last C. Due to (or as a c	onsequence of):	·	-101112-00-00						
8760, O	cate be executed physician and the burial-transit	dical	d									
õ	ntifica ng ph as th	Med	IF FEMALE:									
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Section 1 Section 1 Pregnant at time 1 Section 1 Secti	∃Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delivery Month Day Year				
٦.	that the ed by detac	, Ph	Part II. Other significant conditions contributing to death but r	not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribu	te to the cau	use of death?		
Records,	quires n sign ald be	d by					1 □ Y	es 2 No 3	☐ Probably	4 ☑Onknown		
S	aw requir s been si 2 should	Completed					24a. Was a	an 24b. We	re autopsy fir	ndings available on of cause of		
	The la	mo			-		autop: perfor 1∐ Yes	med?   dea	r to completion th?  Yes 2 ☐ N			
Ita	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only or					
7	hysic this co	L <sub>O</sub>	1  Yes 2 No Hospital: 1 Inpatient		SIIL SOLDOA			ence 6 Other	Specify)			
Division or Vital	Attending Physician: r death. ector: After this certifica by the funeral director, I	ion:	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Y	(ear) 28b. Time Injury	Wo	ryat rk? ]Yes 2 ⊟No	28d. Describe h	ow injury occurred				
isi.	Attenc death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (	- At home, farm, s			28f. Location (S	treet and Number	or Rural Rou	te Number,		
2	ai or / s after if Dire	Certification:	4 ☐ Homicide determined building, etc. (	Specify)			City or Tow	n, State)				
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of the best	camination and/or								
	To the within 2 To the complete	Ž	29b. Signature and title of certifier		29c. Licen		2	29d. Date signed (/	Nonth, Day,	Year)		
	20			7.0,	Δ:	59062		January	20, 20	009		
	*		30. Name and address of person who completed cause of deal			0 11.	A. p. A	,				
	Sta	ite	31. Date filed (Month, Day, Year) 22. Registrar's	Signature	cluedera	Baltim	or MA	21215				
	Regist		JAN 29 2009 Senetia	A. par	Elvedera							
				-								

State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 ear 26 Physician 5:25 P M JANUARY NATHANIEL CHARLES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 4 1940 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 XM 2 □ F MISSOURI MAY 4 Director 68 577-54-9447 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ust be notified at 1 XYes 2 No Director UPPER MARLBORO PRINCE GEORGE'S MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò USA 23a 20774 9407 CAROL STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 Is marked other than "natural", or items traumatic event, It = Medical Example in the med 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2/☐ No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+) PRIVATE 12 should be filed with and Mental Hygier 7 Is marked other the CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EMERSON BEVERLY HARVEY FINLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9407 CAROL STREET UPPER MARLBORO, MARYLAND 20774 BERNICE G. FINLEY/WIFE Health tem 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit, Pages Department of Important: If it any injury or o to 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 1/30/2009 RIVERDALE, CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final cell concer of Non-small **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Hyper tension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Mre II requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. ģ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 KNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending P nours after death, meral Director: After y filled in by the funer After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054981 n. Bholllin

Registrar

31. Date filed (Month, Day JAN 2 9 2009

Mukemil Abdella, mo 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 26, January 9:32 A James Richard Fincham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Hospital Prince George's Cheverly 8. Date of Birth
(Month, Day, Year)
July 18, 1938 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**™** M 2□ F Months Days Hours Min. Country) Virginia 70 219-34-9546 Director Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a, State 10h. County 28a-f show ust be notified at 1X Yes 2 □ No Director Md. Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 4804 70th. 20784 U.S.A. 23a Funeral items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, other traumatic event, the Medical Examiner :-Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates unknown ō 1 ☐ Yes 2 ☑ No Specify. Specify: ģ 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Washington Bible Elementary/Secondary (0-12) College (1-4or 5+) College Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tames Ε. Fincham Dorothy Musgrove ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Fincham (Wife) 70th. Pl. Hyattsville, Md. 20784 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Jan.28,2009 Riverdale, Md. 4 ☐ Donation 5 ☐ Other (Specify) Chambers Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIAC Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner The law requires that the death certificate be executed ending physician and use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year signed by the a 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 2 1 ☐ Yes 2 ☐ No spital or Attending Physiclan; Thours after death.
neral Director: After this certificate iy filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

09-00951
Jeremy Fletcher

T. Concordor Name   File My Name	y Fletcher	State of Mary 1- For State Registrar	land / Department of I Certificate of I		rgiene Reg. No. 20 (	09 0418
11610 Emack Road  11610 Emack	Physician/ cal Examiner	1. Decedent's Name (First, Middle,Last) $JEREMY \qquad D \ . \label{eq:JEREMY}$			Date of Death     Month Day Year	
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The second program of	er death with to a constitution of the constit	11. Marital Status 1 X Never Married 2 Married 1 Ye	Forces? If Yes	Decedent of Hispanic Origin? (Sps, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Amer White, etc.	ican Indian, Black,
Security	72 hours after "natural", al Examiner leted by	or Dates:	grade completed) 16a. Decedent's	s Usual Occupation (Give kind of w	ork done 16b. Kind of Business/	Industry
A Donation of Other Specify    A Donation of Other Specify   MARYLAND NAT'L. CEM. 2-7-2009   LAUREL, MD.			<b>1.</b>	18.Mother's Name	(First, Middle, Maiden Sumame)	Y TEMP.
A Donation of Other Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MARYLAND NAT'L. CEM. 2-7-2009 LAUREL, MD.  2-1 Signature of Fignerial Serves be completed from the Complete of Specify  MOOO91 CLEVELAND AVE., RIVERDALE, MD.  2-2 Specific Specify of Speci	2 should be h and Ments 27 is mark imatic even To B	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Street and Number or F	Rural Route Number, City or Town, State	e, Zip Code)
23a. Part i. Enter the classes, or complications—filting uses on each line.  This immediate Cause (Find disease or condition resulting in death)  25a. Part i. Enter the classes, or complications—filting uses on each line.  This immediate Cause (Find disease or condition resulting in death)  25a. Part i. Enter the classes, or complications—filting uses on each line.  This immediate Cause (Find disease or condition resulting in death)  25a. Part i. Enter the classes, or complications—filting uses on each line.  This immediate cause (Find disease or condition resulting in death)  25a. Part i. Enter the classes, or complications—filting uses on each line.  This immediate cause (Find disease or condition resulting in death)  25a. Part i. Enter the classes, or complications—filting uses on each line.  This immediate cause (Find disease or condition resulting in death)  25a. Use of the class of class of the cause of class of the conditions.  25b. Uses cause referred to medical each of the class of death of the cause of death or country of the class of death or class of the class of death or country of the class of the class of the class of death or country of the class of the	Pages I and ient of Healt mt: If item ir other trau	20a. Method of Disposition  1 X Burial 2 Cremation 3 Remove	20b. Place of Disposit crematory or other	on (Name of cemetery, er place)	Date 20c. Location - City or	r Town, State
failure List only one cause on each line.  Sequentially list conditions resulting in death   List during in death		21. Signature of Funeral Service Licensee	M00091 58	nme and Address of Facility AMBERS FUNERAL I 01 CLEVELAND AVI	HOME & CREMATORIUM	P.A. 20737
The property of the property o	Medical	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	iac arrhythmia s a consequence of): ted cardiomyopat		·	Between Onset and
The product of the pr	uted dansit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or a		T.		
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  February 3, 2009  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	te be exect hysician an burial - tr			7, per,ME G889		rv
29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  February 3, 2009  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	death certifica he attending pl for use as th	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 U	ve birth 2 Feta egnant at time of death 5 Oth		1 17mm	
29b. Signature and title of certifier  O.C.M.E.  29c. License number O.C.M.E.  Pebruary 3, 2009  30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	uires that the n signed by the detached		g to death but not resulting in the ur	nderlying cause given in Part I.	1 Yes 2 No 3 Pro	bably 4 Unknown
29b. Signature and title of certifier  O.C.M.E.  29c. License number O.C.M.E.  Pebruary 3, 2009  30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	The law req				autopsy prior to death?  1 ✓ Yes 2 No 1 ✓ Y	completion of cause of
29b. Signature and title of certifier  O.C.M.E.  29d. Date signed (Month, Day, Year)  February 3, 2009  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ysician: his certil director	25. Was case referred to medical examiner?	Inpatient 2 ER/Outpatient	Other:		er: Scene
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30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To the II within 24 To the Fucompletel	(Check only one) 2 Medical Examiner: On the ba and mann 29b. Signature and title of certifier	sis of examination and/or investigation	on, in my opinion, death occurred a	at the time, date and place, and due to t	the cause(s)
Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		OL WOLL IND	cause of death (Item 23a)	O.C.M.E.	February 3, 200	9
State 31. Date filed (Month. Day Year) 32 Registrar's Signature		Donna M. Vincenti, MD Assista		Penn Street, Baltimore, M	ID 21201	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GRAEN Physician 028 RENDA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF THE CHEASPEAKE HARWOOD ANNE ARUNDEI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 F Yrs. Director 579-64-7757 12 FEB 1949 WASHINGTON, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Evantinar must be notified at appraisal. ty⊡Yes 2 No Director PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15108 NASHUA LANE Funeral 20716 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2MNo Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No 2 BLACK 3 Widowed 4 Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th HOMEMAKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ KENNETH E. SMITH SR. GLORIA M. FIELDS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YOLANDA BOOZER/DAUGHTER 15108 NASHUA LANE BOWIE, MARYLAND 20716 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 2/2/2009 CLINTON, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARYNGICHI Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknowf Part II. Other significant conditions contributing to death/but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ✓Yes 2 No 3 Probably 4 Unknown Be Completed NEUMONI 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2<sup>™</sup>No 2 No 1 ☐ Yes MANDRIN 25. Was case referred to medical examiner? 26. Place of Death (Check only one) HOSPICE Other: 4 Nursing Home 5 Residence 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To HOUSE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
Accident 5 Pending within 24 hours after deau.

To the Funeral Director: A' 1 ☐ Yes 2 ☐ No investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) mod manner stated. 29a. Certifier Medical (Check only 29b. Signature end title of certifier d. Date signed (Month, Day, Year, 21 person who completes cause of death (Item 23a) (Type, Print) Name and address of 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 2 9 2009

			For State Registrar	State of M	aryland		artment of F		nd Ment	al Hygier	71114	04188	3
	Physici	an	1. Decedent's Name (First, Middle,	Last)						ate of Death	Day Year	3. Time of Death	
*	/Medic			Gravatt					Ja		2009	0335 M	1
	Examir	er	4a. Facility Name (If not institution,	,			4b. City, Town, or	_	Death		lc. County of Death		
			Prince George  5. Social Security Number		⊥ ge (In yrs. las	t hirthday)	Chever If Under 1 Year	⊥y If Under 24	Hrs. I a no		rince G	eorges  place (State or Foreign	<u></u>
	Funeral Director		578-28-2708	1 M 2 VE	86	Yrs.	Months Days		Min. Dec	te of Birth lonth, Day, Yea	922 Vir	ginia ginia	1
	ъ		Usual Residence of Decedent						1000		722 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	911114	_
	show	_	10a. State 10b. County			Town or Loc						10d. Inside City Limits	
	8a-f	ecto	DC			Wash.	ington,	DC				1. A Yes 2 □ No	
	with th	ä	10e. Street and Number				10f. Zip Code	1.0		10g. (	Citizen of What Cou	intry?	
	eath	Funeral Director	401 Chaplin S	12. Was Decedent		13 V	200		2 (Specify V	as or No	USA 14. Race - Amer	loon Indian	
<b>'</b> O	r iten iner	ᇤ	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 □Yes 21X	,		Vas Decedent of H f Yes, specify Cuba	n, Mexican, P	uerto Rican,	etc.)	Black, White,	etc.	
<u>8</u>	al", o	ğ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 2MNo	Specify:			Specify: Bl	ack	
2	filed within 72 hours after death with the Maryland Hygene. Wher then "natural", or items 23a or 28a-f show ant, the Madical Extendine must be rudfilled at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usual Occup	ation during most of	f workina	16b.	Kind of Business/Ir	ndustry	
12	vithin	mp	Elementary/Secondary (0-12)	College (1-4or 5	5+)	`life. L	kind of work done o	1)		177	- A1 C		ı
d 2	Hygie ther ther int, II	ပိ	12th 17. Father's Name (First, Middle, Li	ast)			Nurse	18 Mother's	Name (First	, Middle, Maide		Overnmen	L
an	should be f and Mental I s marked of umatic eve	To Be	Allie G. Ty						illie				
ary	shoul and M s mar umat	F	19a. Informant's Name/Relationshi		- 1	19b Mailin	g Address (Street				v or Town, State, Zi	p Code)	
ž	ss 1 and 2 sof Health ar item 27 is		Agnes McCowin	/Sister		Colui	mbia, V	n nii. A	2303	8			
aitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Extrainer must be rediffied at once.		20a. Method of Disposition 1    Burial 2 □ Cremation 3		20b. Plac	e of Dispos	sition (Name of patory or other place	- :	Date	20c.	Location - City or T	own, State	_
Ĕ	Pages ment of ant: If it		4 □ Donation 5 □ Other (Spe		Cem	eter	7		/29/0	9   CO	Olumbia,	VA	
Bail	ermit.		21. Signature of Funeral Service L	censee						_		eral Home	
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	Physician /Medical		disease or condition resulting in death)				Disease	e					_
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		ner	Sequentially list conditions,	b. Due to (or as	a consequer	nce of):							_
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60,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ũ	resulting in death) Last	Due to (or as	a consequer	nce of);							
8760	icate physi the t	dical	•	d									_
9 X	eath certific attending p for use as f	/Me	IF FEMALE:	23c. If yes, outcome	of pregnanc	v					02d Data of dali		
Box	death e atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)	/			23d. Date of delive Month	Day Year	
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ပ္ထ	law r las be	Completed							24	la. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of	
<u> </u>	ician: The lav certificate has rector, page 2	Son							11	performed? □Yes 2 <b>X</b> N	death?		
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<u> </u>	ili di	-T	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie	ent 2 🔀 EF	NOutpatient  Bb. Time of		4 LI Nursir			6 ☐ Other (Speci	fy)	_
0	ding h. After fune	ertification:	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y, Year)	Injury	28c. Injury Work	/aτ ? Yes 2 □ No	28d. D	escribe how inj	ury occurrea		
Division	Atten r deat sctor: by the	ifica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Inju	ury - At home	e, farm, stre		.00 2	28f. Lo	cation (Street	and Number or Run	al Route Number,	
á	al or	Cert	4 ☐ Homicide determin	building, et	c.*(Specify)				Cit	ly or Town, Sta	ite)		b
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	Physician: To the best xaminer: On the basis o and manner sta	of examination	edge, death n and/or inv	occurred at the ting estigation, in my o	ne, date and p pinion, death o	place, and du occurred at the	e to the cause he time, date a	(s) and manner as nd place, and due t	stated. o the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier		,		29c. License	e number		29d. E	ate signed (Month,	Day, Year)	-
			1	freed			D589	957		Ja	an. 23,	2009	
	3		30. Name and address of person w										
			Gary Little, i	MD 3001 Ho	ospit	al Di	rive, Cl	never1	ly, M	D 207	785		_
	Sta Registr		JAN 29 2	32. Registr	ar s signatur	hour	Les .						
DHN	MH 17 Rev 1/20		VALUE OF A	- Deneson	10.	C. Wall	-						_

		•	For State Registrar	State of Marylan	d / Depa <i>Ce</i>	artment of F rtificate of I	lealth ar D <i>eath</i>	nd Mer	ital Hygi Re	ene g. No. 200	9 04189
	Physicia /Medic		1. Decedent's Name (First, Middle, La Marcella Gore	ast)		· · · · · · · · · · · · · · · · · · ·			Date of Death Month anuary	25, 200	3. Time of Death 6:00 P. M
1	Examin		4a. Facility Name (If not institution, gi Laurel Regional	ve street and number) Hospital		4b. City, Town, or Laurel	Location of E				George's
	Funeral Director			Sex 1 □ M 2 TF 7. Age (In yrs.	last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. 1 Min. Ma	Date of Birth Month 29	1920 We	Birthplace (State or Foreign Stronginia
	Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince		y, Town or Lo urel	cation					10d. Inside City Limits 1 X Yes 2 □ No
	3a or 28e	Funeral Director	10e. Street and Number 7700 Cherry Lane			10f. Zip Code 20707	,		10	og. Citizen of What United	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extraction is not be notified at once.	by Funera	11. Marital Status  **Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 XNo	lispanic Origir an, Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- in, etc.)	Black, W	American Indian, /hite, etc. White
1215-0	vithin 72 ho sne. than "natur ie medical	Completed by	15. Decedent's Elementary/Secondary (0-12)	Education rade completed)  College (1-4pr 5+)	16a. Dece (Give life. Teac	dent's Usual Occup kind of work done DO NOT use retired her	oation during most of d)	f working		16b. Kind of Busine Educati	•
and 2	d be filed v ental Hygie ced other t c event, th	To Be Co	17. Father's Name (First, Middle, Lass Claude Gore	t)	1000		18. Mother's		rst, Middle, N .dwin	faiden Surname)	
laryl	2 should and Me is mark	ř	19a. Informant's Name/Relationship			ng Address (Street					
Baltimore, Maryland 21215-0036	ages 1 and ant of Health t; If item 27 y or other to		Audrey Rose Jewe	20b. F	Place of Disponentery, cre	osition (Name of matory or other place	ce)	Date		20c. Location - City	
Baltir	permit. P Departme Importan any Injur		4 □ Donation 5 □ Other (Special Service Lice		B	2. Name and Addre	ss of Facility Borgwa	rdt E	unera	l Home, F	
68760,	ificate be executed  J physician and its the burial-transit	edical Examiner	23a. Part 1. Enter the disease, or corshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Litter University Cause (Disease or injury that initiated events resulting in death) Last	mplifications that caused the deat y one cause on each line.  Sepsis  Due to (or as a consect  Pulmonary  Due to (or as a consect  c.  Due to (or as a consect  Due to (or as a consect  d.	uence of): Edema	ter the mode of dyii	ng, such as ca	ardiac or re	spiratory arre	sst,	Approximate Interval Between Onset and Death hours  days
O. Box	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of	al death 3	□ Ectopic pregnand □ Other (specify) _	су			23d. Date o Month	f delivery Day Year
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of Vital Records,		Completed							24a. Was a autops perforr 1 □ Yes	y prio	e autopsy findings available r to completion of cause of th? Yes 2 XNo
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ion of	To the Hospital or Attending Physiciam: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification: To	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	of 28c. Inju Wor	ry at	28d		ow injury occurred	<i>Specny)</i>
Division	tal or Atters after de al Directo ed in by the	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, si	reet, factory, office		28f.	Location (Si City or Town	treet and Number on, State)	or Rural Route Number,
1	Hospital 24 hours Funeral etely filled	dical	29a. Certifier 1 ★ Certifying I (Check only one) 2 ← Medical Ex	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	ime, date and opinion, death	place, and occurred	due to the cat the time, d	ause(s) and mann ate and place, and	er as stated.  I due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Palani		29c. Licen:	se number	7	2	9d. Date signed (A	Nonth, Day, Year)
	R		30. Name and address of person wh	o completed cause of death (Ite	m 28a) (Type	, Printy MARGE	A. D.	OBY NIS	, M.D.	A 20	707
	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature	U p	Cul		, ,, ,,	00/	

		For State of Registrar	Maryland /	Depai <i>Cert</i>	rtment of F tificate of I	lealth and Death	Mental Hy	giene Reg. No.	9 04190
Physici	an	1. Decedent's Name (First, Middle, Last)  ROBERT WILLIAM GATT, JR					2. Date of De- Month JANUAR	ath Day Va	3. Time of Death 4:30 P M
/Medic		4a. Facility Name (If not institution, give street and nur.			4b. City, Town, or	Location of Dea		4c. County of D	7.50
Examin Funeral Director	er	9204 Carendon Court	7. Age (In yrs. last)		Upper Ma If Under 1 Year Months Days	arlboro	s. 8. Date of Bir	Prince (	
- ud		Usual Residence of Decedent	100 City Tr	our or Loo	ation				10d. Inside City Limits
aryla shov	5	10a. State 10b. County	10c. City, To						1X□Yes 2□No
the M	Director	Maryland Prince George  10e. Street and Number	s Upper	r Marl	Lboro 10f. Zip Code			10g. Citizen of What	
3a or		9204 Carendon Court			20772			USA	,
ite, with yield to ZIZISTOOOO  I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expolling out to confill at a	Funeral	<u> </u>	2 💢 No	lf.		an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	Black, W	American Indian, Vhite, etc.
72 hours natural",	eted by	3 Widowed 4 Divorced Fees, Given 15. Decedent's Education (Specify only highest grade completed)	ates:	6a. Decede	ent's Usual Occup	ation	orkina	Specify: 16b. Kind of Busine	White ess/Industry
filed within Hygiene. Other than "	Completed	Elementary/Secondary (0-12) College (1		life. D	ONOT use retired	1)		Chaney E	nterprises
be file ttal Hy d oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Surname)	
should be and Mental is marked of umatic even	우	Robert Gatt, Sr.  19a. Informant's Name/Relationship (Type. Print)		tOh Mailina	Address (Street	Mary Gr	- 3	er, City or Town, Sta	to Zin Code)
od 2 st dd 2 st lth an 17 is r traur		Kathy Gatt/ Wife	I	_				lboro, MD	
ic, iv s 1 and f Health ftem 27 other tr		20a. Method of Disposition	20b. Place		ition (Name of atory or other place		Date	20c. Location - City	
Pages nent of I int: If Ite		1 ☐ Burial 2 X Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	State		Crematory	i	2/2009	Glen Burn	fa MD
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	ACIAN	22.	Name and Addre	ss of Facility Ro	bert E.	Evans Functie, MD 20	eral Home
Physician	2 U	23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final	ach line.	Do not ente	r the mode of dyir	ng, such as cardi	ac or respiratory a		Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)  Due to (	or as a consequenc	ce of):	arter	7 acse	ase		3 years
pg ti	iner	Sequentially list conditions, if any, leading to immediate and thousand Cause (Disease or injury	or as a consequenc	ce of):					
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	come of pregnancy pirth 2 ☐ Fetal dea nant at time of death own	ath 3	Ectopic pregnanc Other (specify) _	у		23d. Date of Month	delivery Day Year
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n 24 hours n 24 hours le Funera	edical C	29a. Certifier (Check only one)  Certifying Physician: To the 2 Medical Examiner: On the b and mani	best of my knowled asis of examination ner stated.	dge, death and/or inv	occurred at the tile estigation, in my o	me, date and pla	ce, and due to the curred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (M	onth, Day, Year)
		1 de le	3 n	9		0358	20	1/261	09
D 11		30. Name and address of person who completed caus				t-	_		_
0010		Peter ECKYSEAG M. P. 1 31. Date filed (Month, Day, Year) 32. R	4300 Ga	llant i	tox Lav	e #110	BOWE,	MD 2071	4
Sta Registr		JAN 2 9 2009	egistrar's Signature	9. 10	alle				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JANUARY 29 2009 12:08 P M TATIANA GAGARINE V. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON 9711 OLD NATIONAL PIKE BOONSBORO 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F 89 FLORIDA Director FEB. 13, 1919 577-24-1650 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND WASHINGTON BOONSBORO 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 72 hours after death with 9711 OLD NATIONAL PIKE 21713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ WHITE 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Unk. HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be LEONID VASSILIEFF LUDMILA N. KOURTENER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) f Health tem 27 i OLD NATIONALPIKE, BOONSBORO, MARYLAND MICHAEL GAGARINE/SON item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or ott 15 Burial 2 ☐ Cremation 3 Removal from State Mar.16,2009 ARLINGTON, VIRGINIA 4 Donation 5 ☐ Other (Specify) ARLINGTON NAT. CEM. 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME Paul M. Dean 7606 Old National Pike, Boonsboro, MD Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that or is a dithe death. Do not enter the good of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Jend De Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner certificate be executed that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant death 3 ☐ Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Z res 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? 1□ Yes 2□ No certificate Division or Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 7 100 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 / Hatural 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident al or Attend s after death il Director: / the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral C 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie 36655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mustiren, MD 20140 Street. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB n 2 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Cochenour **Physician** 21.16 PM Dandra January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (St. Country) | Min. | Wwenteer 4, 1966 | Michigan 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2 **X** F 42 Director 462-57-6249 Usual Residence of Decedent filed within 72 hours after death with the Maryland or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pennsylvanija Adams Gardners 1 ☐ Yes XXNo Director 10f. Zip-Code 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a o 17324 USA 10 Idaville-York Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 14. Race - American Indian. Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify If Yes. Give p 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Financia1 Teller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McNett Ronald F. Frazho Lois C. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Idaville-York Springs Road, Gardners, Pennsylvania
17324 19a. Informant's Name/Relationship (Type. Print) 2 Steven H. Gochehour (Husband) Health tem 27 i other t or other 20a. Method of Disposition
1 ☐ Burial XXCremation 3X Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State cemetery, crematory or other place)
Hollinger Funeral & Crematory 2/2/09 ō permit. Page Department or Important: If any injury or once, Mt. Holly Springs, PA 4 ☐ Donation 5 ☐ Other (Specify) maye of Funeral Service Licensee 1 T. Loghstampfor Lochstampfor Funeral Home, Inc. Ochstamo M-00849 48 S. Church St., WAynesboro, PA 17268 Part 1. Enter the disease, or complications that revied the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earl lin. Approximate 23a. Part 1. Enter the disease Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Thombosis Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and is the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) detached the signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has page Yes 1 Tes 2 🗌 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \triangle \text{ Nursing Home} \) 5 \( \triangle \text{ Residence} \) 6 \( \triangle \text{ Other (Specify)} \) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 1 Natural 28c. Injury at Work? funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After (Month, Day Hospital or Attending 5 Pending investigation Injury To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES DOD January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State FEB 0 2 2009 Registrar

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Division of Vital Records,  To the Hospital or Attending Physician: The law requires to within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director.	Certification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pe 2 Accident inv	nding estigatio	28a. Dat (Mo	XInpatient e of Injury onth, Day, Yea	2 ER/Outpat 28b. Time Injury		28c. Injui Wor	4 LI Nursing	Home 5 Re 28d. Describ			(Specify)	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			-	matory or other place 11 Cemete	Ja	n. 30,	G			
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88 2 8 8	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spri										ag_MD_20901	
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each li	d the death ine.	. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
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14		30. Name and address of person v	who completed cause of	death (Item	23a) (Timo		- 00		uan	mary:	28, 2009	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 26, **Physician** Grace Amelia Hamilton 2009 9:45A. January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) May 21, 1924 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours New York 1 □ M 2 🖫 F 579-20-7762 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Maryland Prince George's Greenbelt Director 10f. Zip Code 20770 10g. Citizen of What Country? 10e. Street and Number 6-D Hillside Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
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Mt. Olivet Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 6 1/29/2009 Washington, D.C. Injury o 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA
4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 years Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Accident **Physician** /Medical Due to (or as a consequence of): Examiner Dementia years Sequentially list conditions, it any cause to immer the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examine 2 years burial-transi Seizure and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the b IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. a□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Syncope; Osteoporosis 2 No 3 Probably 4 Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 has certificate 1∐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🗚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical k only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Nurse Practitic and place, and due to the cause(s)

Division or Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Millie Jarrell, CRNP 14300 Gallant Fox Lane, #222 Bowie, Maryland 20715 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

		-	_ FOI	partment of Health and N <i>ertificate of Death</i>	fental Hygier Reg.	2009 05 95								
	Physicia	an l	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	3. Time of Death								
	/Medic	al	Edgar J. Haines  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		25, 2009 4:50P. M								
	Examin	<b>.</b>	9000 Briarcroft Lane	Laurel		Prince George's								
. 2	Funeral Director		5. Social Security Number  236~46~1264  6. Sex 1    N M 2□ F  7. Age (In yrs. last birthda yrs.)  7. Age (In yrs. last birthda yrs.)	Months Days Hours Min	8. Date of Birth (Month, Day 73 Aug. 6, 193	9. Birthplace (State or Foreign West Virginia								
	rland ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits								
	a-f sh	ctor	Maryland Prince George's Laurel			1 ☐ Yes 2 ☐XNo								
	h with the 23a or 28 st be no	Funeral Director	10e. Street and Number 9000 Briarcroft Lane	10f. Zip Code 20708		citizen of What Country? ited States								
036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Brican, etc.)	14. Race - American Indian, Black, White, etc. White Specify:								
ν O	72 ho 'natur dical	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	king   16b	. Kind of Business/Industry								
21215-0036	within iene. than "	Completed by		ding Engineer		exandria House								
land 2	ld be filed ental Hygi <b>ked other</b> ic event, t	To Be Co	17. Father's Name ( <i>First, Middle, Last</i> ) Edgər Edwin Həines		e (First, Middle, Maid yon Polan									
Maryland	nd 2 shou lith and M 27 is mar r traumat	-		ailing Address (Street and Number or Ru. 00 Seguoia Lane Bel										
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Rurial 2 Cremation 3 Removal from State cemetery, o	sposition (Name of crematory or other place)		c. Location - City or Town, State								
ţ.			4□Donation 5□Other (Specify) Metropo	litan Crematory 1/2		, ,								
Ba	permi Depar Impor any Ir		Daralel V. Bujwardt		oad Beltsv	ville, Maryland 20705								
3			23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximat Interval Bet Onset and I ung unspecified  Malignant Neoplasm, bronchus and lung unspecified											
	Physician /Medical		disease or condition resulting in death)  Malignant Neopl  Due to (or as a consequence of):	asm, bronchus and	lung unspe	clfled								
	Examiner		Sequentially list conditions. Chronic Airway	Obstruction										
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
o,	icate be executed physician and s the burial-transit	Exal	that initiated events resulting in death) Last											
8760,	cate be ohysici the bu	dical	d											
.O. Box 6	ath certif ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes . 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year								
Δ.	res that the de signed by the a be detached t	y Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?								
ords	v requires been sign should be	ed by			1 ☐ Yes	No 3 Probably 4 ☐ Unknown								
Records,	The law re cate has be page 2 sho	Completed			24a. Was an autopsy performer 1 Yes 2 ₺	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 XNo								
Vital		Be C	25. Was case referred to medical examiner?		1 Yes 2 th (Check only one)	THO TELES ZEENO								
or V	phys this al diil	မှ	Hospital:		ome 5X Residence	e 6 Other (Specify)								
lon	Attending r death. ector: After by the funer	tion	1 Natural 5 □ Pending (Month, Day Year) Inju		2od. Describe now i	njury occurred								
Division	or Atter after dea Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)								
B	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)								
	G		Yaturr.00	1766665		01/26/09								
			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) (OSI) COUR # 200	LAPGO	mn 20774								
	Sta Regist		31. Date filed (Month, Day, Year)  JAN 2 9 2009  32 Registrar's Signature	Bares										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 19, Mary Jane Hughes 2009 6:55 a<sup>M</sup> January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Medical Center Fort Washington Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 XF 577-44-6717 20, 1907 Christianburg, Va Director 101 Feb. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Prince Georges Fort Washington 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 Bentham Ct. 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Counselor Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Charles Rose Bessie Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; If Item 27 any injury or other to Dorothy S. Gregory / Daughter 6317 Bentham Ct. Ft. Washington, Md. 20744 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tx Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 1/26/2009 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Alexander S. Pope, P.A.
2617 Pennsylvania, Ave 20
Washington, P.A. 21. Signature of Funeral Service Licens M0108 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign l be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 🗌 No 2X No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2x No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 npatient this funeral ( 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: .al or Atter...
.urs after death.
.eral Director: A.
.v filled in by the 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45365 January 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Sidarous, M.D. 11701 Livingston Rd/ #101 Ft. Washington, Md. 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:00 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (Sta 7/Age (In yrs. last birthday) Security Number **Funeral** Year) Months 1 □ M 2 X F Days Director Usual Residence of Decedent 10d. Inside City Limits Show 10a. State 10b County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Inportant: If Health and Mental Hyglene is Insured: Inportant: If Hear 21s an rarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In a Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Deceden Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NQT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname) Be 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informarit's Name/Relationship (Type. Print) SOWIE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Logation 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lije. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Weeks Physician /Medical Due (or as a consequence of): Examiner neumonia Sequentially list conditions, if any conditions, if any conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed burial-transi ST44E and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) signed by the a d be detached f 2 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 1 ☐ Yes 3 Probably 4 Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐Yes 2 🗷 No 1 □Yes spital or Attending Physician: Thours after death.
Ineral Director: After this certificat filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signati

State
Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type,

lama

01010
Craig Hanson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

aig Hanson	P	State of Maryland / Department of Health and Williams  For State  Certificate of Death  Registrar	Reg. No. 2009 041
Physicia	<b>1</b> / 1	1. Decedent's Name (First, Middle,Last)  Craig S. Hanson	2. Date of Death  Month Day Year February 3, 2009  3. Time of Death 1530 hrs
edical Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Local	4c. County of Death Prince George's
Funeral Director		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Wastry), D.C.
	40	Usual Residence of Decedent	10d. Inside City Limits
d liow any e.		Md. P.G. Oxon Hil	
Maryland r 28a-f show	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
D 21215-0036 should be filed with the Maryland and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be rigified at dnee		5020 Leland Drive  11. Marital Status 1 Never Married 2 Married 1 Yes 2 X No  2074  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  African-
s.after de	<u>a</u>	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No spring year or Dates:	(Give kind of work done 16b. Kind of Business/Industry
0036 within 72 hours a igne igne ier than "natura Medical Examin	pleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  1 yr  Manager	Restaurant
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	$\circ$	17. Eather's Name (First Middle, Last)	Mother's Name (First, Middle, Maiden Surname)  Pearline Harvard
21215-C		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street an	nd Number or Rural Route Number, City or Town, State, Zip Code)  LVE, Oxon Hill, Maryland 20745
52555	- 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemeter	
Baltimore, permit Pages I am Department of Heal Important: If iten injury or other tra		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Lincoln Mem. Cem.	02/10/09 Suitland, Maryland
Balt permit Depart Impor injury		21. Signature of Funeral Service Licensee  22. Namering divisions 4925 Burrouce  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	firther on & Sons Co., Inc.  ghs Ave., N.E., Washington, D.C. 20019  chase carriage or respiratory arrest, shock, or heart  Approximate Interval
am and transit	Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
O, e be exec ysician ar burial - ti	edical	X UNPENDED AMENDED 23a,PII,2/,perME, g888	23d. Date of delivery
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed that not after death.  Funeral Direction After this certificate has been signed by the attending physician and retain by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Ectopic pregnancy Month Day Year
, P.O. B ires that the d signed by the lbe detached	5	Chronic alcohol use	ren in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 ✓ Unknown  24a. Was an 24b. Were autopsy findings available
Division of Vital Records, tal or Attending Physician: The law require as after death.  Director: After this certificate has been siled in by the Inneral director, page 2 should be	ompleted		autopsy performed? prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No
Vital Rec ysician: The l his certificate l director, page	BeC		of Death (Check only one)  Other;  Nursing Home 5 Residence 6 ✔ Other: Scene
n of Vit ding Physic h. : After this e funeral dir	ion: To	D 1 ✓ Yes 2 No 27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury	at Work? 28d. Describe how injury occurred as 2 No
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office but (Specify)	illding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospit within 24 hour To the Funers			te and place, and due to the cause(s) and manner as stated.  death occurred at the time, date and place, and due to the cause(s)
To the within To the comple	Medical	and manner stated.  29c. License  29c. License  O.C.N	number 29d. Date signed (Month, Day, Year)
		20. Name and address of person who completed cause of death (Item 23a)	
R		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Str	reet, Baltimore, MD 21201
5	State	te 31. Date filed (Month, Day, Year) 32. Regis rar's Signature	

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

			For Amend Item 23 State Registrar	a \$1 <b>2</b> 46 (1141,313 <b>0338</b> 0)	OP <b>P27/09</b> Certifica	ate of Dea	th and M th	ental Hy	giene Reg. No. (	2009	04200
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	th Day	Year	3. Time of Death
-	/Medic Examin	al	PRISCILLA  4a. Facility Name (If not institution, give	HUGHES	. 4b. Ci	ty, Town, or Locati		Janua	+	ounty of Death	1 9:40 A M
	Funeral Director	C	Laurel Reg 5. Social Security Number 6. Social Security Number 1	ional Hospit			nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da MAR . 2 (	h v, Year)	Prince 9. Birth	
	Maryland	tor	Usual Residence of Decedent           10a. State         10b. County           MD         PRINCE		Town or Location						10d. Inside City Limits
	or 28a	Director	10e. Street and Number		10f.	Zip Code	-		10g. Citize	n of What Cou	ntry?
	s 23a	eral	702 GORMAN AVE	#103	12 Was Da	20707	Origin? (Spe	oiby Voc or No		ERIAN . Race - Amer	iona Indian
920	urs after de al", or Item	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates:		cedent of Hispanic pecify Cuban, Mex 2 No Spe		Rican, etc.)		Black, White,	ACK
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)		16a. Decedent's U (Give kind of life. DO NOT	work done during i use retired)	most of workin	-		of Business/Ir	
d 2	filed w Hygie other t		12th 17. Father's Name (First, Middle, Last)		·			(First, Middle,			10
ylan	should be ind Mental marked o	To Be	DANIEL COLE			EL	IZABE	TH	COI	LE	
Mar	12 sho th and 7 is ma trauma		19a. Informant's Name/Relationship (7	ERRING / DATER	19b. Mailing Addre	ess <i>(Street and Nu</i>		l Route Numbe LAURI			
Baltimore, Maryland	es 1 and of Health fitem 27 r other tu		20a. Method of Disposition	20b. Plac	ce of Disposition (*)			ate		tion - City or T	
iii	. Pages tment of tant: If it jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemovariiom State DDEM	ERVILLE	CEM.	2/21			ERIA	
Ball	permit. Departm Importa any inju		21. Signatur // Funeral Service Lice	Skeron Ja	164425		ND AV		E WAS		.C. 20002
E			23a. Part 1. Enter the disease, or confishock, or heart failure. List only commediate Cause (Final	one cause on each line.	TC		h as cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque		rction					
	Examiner	_	Sequentially list conditions,	b. (clinic	al suspic	ion for c	ause o	f death	T	1	
	uted d ansit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	inco	retion)	ALL PARTY	i my co	Said Said	0.0	
ó,	ificate be executed g physician and as the burial-transit	i Exa	resulting in death) Last	Due to (or as a conseque							
68760,	ificate by physic s the bi	edical		d							
O. Box (	attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopi	ic pregnancy (specify)			23	d. Date of deli- Month	very Day Year
<u>Ч</u> .	that the		9 ☐ Unknown  Part II. Other significant conditions or	ontributing to death but not resulti	ng in the underlyin	g cause given in P	Part I.	23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires that the d been signed by the should be detached	ed by						1 🗆 Y	es 2	No 3□ Pro	bably 4 🗆 Unknown
Division of Vital Records,	The law recate has be page 2 sho	Completed						24a. Was autop perfor		24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of
Zit2	nysician; Thans certificate director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2/2	Othor		(Check only o		70	
of	g Physier this ieral di	n:To	27. Manner of Death	1 Inpatient 2 KE	8b. Time of Injury	28c. Injury at Work?		ne 5 Resid 28d. Describe h			ify)
sior	tending Feath. tor: After the funer.	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 □ Yes					
Ο̈́	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Certification: To	4 Homicide determined	building, etc. (Specify)				City or Tov	n, State)		al Route Number,
	e Hospital 24 hours e Funeral letely filled	edical		ysician: To the best of my knowl niner: On the basis of examination and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License numl				signed (Month	
	3		/ hm /+	1 honger	A	7229		1.1.1	Jai	nuary	26, 2009
	R		Thomas H. Burgu		ಚa) (Type, Print)	1300 V	regional	1 Hosp	Roda	Emerg	ency Dept. el, MD 20707
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re. E.J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 24, 2009 08:11A.M January Ferby Holmes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 70 Director 251-66-9955 7, 1939 Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 No Director Suitland [ ] Prince George's MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20746 USA 2008 Gaylord Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit De-artment of Health and Mental Hyglen In portant; if item 27 is marked other the arry injury or other traumatic event, If a on 28. Public School 6 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Etta Dobson Ferby Holmes, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2008 Gaylord Dr., Suitland, MD 20746 Doris Holmes/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.29,2009 Clinton MD Resurrection 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service L 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** 000-Sa Juentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy detached for Day Month Year 5 ☐ Other (specify) P.O. ☐Yes 2☐No the 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 X No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 2 ER/Outpatient 3 2 2 1 Yes (DOA 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day, Year) 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

CR 1

State Registrar 31 Date filed (Month

D24208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:02 PM HENRY JANUARY 21 2009 JAMES EDWARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Year) Hours 1 X M 2 □ F Director 48 OHIO 587-06-3014 JAN 11 1961 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show or items 23a or 28a-f showing the strong of 1X Yes 2 □ No Director MDCHARLES PORT TOBACCO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9135 POORHOUSE ROAD 20677 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 □ No AIRFORCE If Yes, Give Year *o*r Dates: 1 Never Married 2X Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No th and Mental Hygiene.
7 is marked other than "natural", or traumatic event, the Modical Exer-BLACK Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5⊹ <u>ENTREPRENEUR</u> PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES HENRY LILLIE MAEMALONE ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any injury or other trau once. 9135 POORHOUSE ROAD PORT TOBACCO, MARYLAND 20677 GLENDA HENRY/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State RESURRECTION CEMETERY 1/31/2009 CLINTON, MARYLAND 21. Signature 1 Fug 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME ral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the decisions, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) allello Examiner 96H1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c I or Attending Physician: The law requires that the death certificate be executed attendeath.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 1 ☐ Yes 2 🕅 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 🖺 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical nanner stated 29b. Signatur 29d. Date signed (Month, Day, Year) JANUARY 29, 2009 D0061652

CR 6

ATUL KATYAL M.D.
31. Date filed (Month, Day, Year)

6 POST OFFICE ROAD SUITE # 101 WALDORF, MARYLAND 20602

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day  $\mathtt{P}^{\mathsf{M}}$ William January 2009 9:00 Burton /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 157-24-9860 78 1 XM 2 □ F Yrs. Director 3, 1930 April Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Extrainer roust be notified at Director District of Columbia 1 Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2020 - 19th Place, SE #101 20020 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No ģ Specify: 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) glementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Burton Harvey Caroline Johnson ည 19a. Informant's Name/Relationship (Type. PrintLegal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health i Regina P. Robinson/Guardian 11709 Butlers Branch Road Clinton, MD 20735 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any Injury or otl 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Feb 2, 2009 Clinton, MD 22. Name and Address of Facility 21. Sin lature of Funeral Service Licent Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) Week /Medical Due to (or as a consequence of): Examiner Prostate Cancer <u>Years</u> Sequentially list conditions, if any, leading to immediate cause that it can be caused to be cau Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. ed by the detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Multi Organ Failure icate has been s Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy certificate 1 □Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Watural n 24 hours aner he Funeral Director: Af moletely filled in by the funeral Director on the funeral property filled in by the funeral property f 1 🗆 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) January 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Raman Tuli, M.D. 10810 Darnestown Road #202 Gaithersburg, MD 20878 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 04204 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3:50 AM Hallett Lobert 28 2009 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Center Baltimore University of If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, 1945) Nov. 17,1945 5. Social Security Number Funeral **X**□M 2□F 63 059-38-1334 Connecticut Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County show ral", or Items 23a or 28a-f shov 1 XYes 2 No Director Seabrook Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 U.S.A. 6929 Storch Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2☐ Married 1 □Yes 21 No If Yes, Give Baltimore, Maryland 21215-0036 'natural", or 1 □Yes 2 □No þ Specify 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Lockheed Martin Co. Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arlene McCarthy Robert J. Hallett မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any Injury or other trau Keith Zembower (Friend) 6929 Storch Circle Seabrook, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/30/09 Beltsville, MD 21. Signature of uneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Par 1. Enter the disease or compost, or heart failure. mmediate Cause (Final **Physician** Aspiration preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): trachevesophaged fistula Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria the death certificate be Physician/Medical as IF FEMALE: nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for Day Month Year 5 Other (specify) ☐Yes 2☐No P.0. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ page 2 should be 3 Probably 4 Unknown Meningitis Completed 24b. Were autopsy findings available prior to completion of cause of death? cell cancer of hypopharynx 24a. Was an autopsy
performed?

1 Yes 2 No 1 ☐Yes 2 ☐ No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No e Hospital or Attendl 124 hours after death. e Funeral Director: A 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Lana de Souze MD P 229 18 01,28,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lana de Soliza MD, 22 South Greene Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year JAN 3 0 2009

32. Registrar's Signature

		1	For State Registrar	State of Marylan		artment of I		F	Reg. No.			
	Physicia	an	1. Decedent's Name (First, Middle	c. Harry				2. Date of Dea	Day Year	3. Time of Death  3:00 A M		
	/Medic Examin	er	4a. Facility Name (If not institution		uter	4b. City, Town, C	Burni	P	4c. County of Death	undel		
	Funeral Director		5. Social Security Number 241-56-4638	6. Sex 7. Age (In yrs. 1 M 2 F 66	last birthday) Yrs.	Months Days	Hours I	Hrs. 8. Date of Birtl Min. Month, Day JAN 20	Year) 1943 NOR	hplace (State or Foreign untry) ΓΗ CAROLINA		
	// Aryland f show	or	Usual Residence of Decedent  10a. State 10b. County  MD ANNE		y, Town or Lo					10d. Inside City Limits  ↑  Yes 2 No		
	vith the h	Direct	10e. Street and Number	RFIELD ROAD # A-		10f. Zip Code 21061			10g. Citizen of What Co	untry?		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show all injury or other traumatic event, Ira Medical Exprisive mant to neithest at one.	by Funeral Director	11. Marital Status  1 Never Married 2 Mari 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No If Yes Give	.S. 13.			? (Specify Yes or No- Puerto Rican, etc.)				
21215-0036	vithin 72 hou sne. than "natura e Medical E	Completed	15. Deceden	at's Education st grade completed)  College (1-4or 5+)	f working	16b. Kind of Business/Industry  PRIVATE						
land 2	ld be filed v lental Hygie ked other ic event, II	To Be Co	17. Father's Name (First, Middle, CHARLIE	Last) PRICE	HOU	Maiden Surname)						
Maryland	12 shoul th and M 7 is mar traumati	<b> -</b>	19a. Informant's Name/Relations			,		or Rural Route Number	er, City or Town, State, 2			
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		PEGINA MCDONA  20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S	3 ☐ Removal from State	Place of Dispo cemetery, crei	osition (Name of matory or other pla Y CEMETE	ace)	Date / 31/2009	20c. Location - City or LANDOVER, M.	Town, State		
Balti	permit. Departn Importa an inju	22. Name and Address of Facility  J. B. JENKINS FT  7474 LANDOVER ROAD LANDOVER, MARY										
4	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	r complications that caused the deat tonly one cause on each line.		ter the mode of dy	ing, such as ca	urdiac or respiratory ar		Approximate Interval Between Onser and Death		
	/Medical Examiner		resulting in death)	Due to (or as a consequence)	quence of):	tery di	sease			years		
,092	ate be executed hysician and the burial-transit	I Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):									
P.O. Box 687	law requires that the death pertificate be executed as been signed by the leter ding physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	al death 3	□ Ectopic pregnar □ Other (specify)	ncy		23d. Date of de Month	livery Day Year		
ds, P	w requires that s been signed to should be deta		1 1	ions contributing to death but not res	+	1	iven in Part I.   Jeale o		obacco use contribute to Yes 2 █ No 3 ☐ P	the cause of death?		
Œ	The law requate has been bage 2 should	dialyier, Type II diaketes							a. Was an autopsy performed? 24b. Were autopsy findings avait prior to completion of cause death? 1 □ Yes 2 ☑ No			
Vita	Physician: The law this certificate has ral director, page 2 s	a	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	ent 3 □ DOA O	ther:	f Death <i>(Check only o</i>	nne) dence 6 □Other (Spe	ecify)		
on of	ding Pl n. After t funera	tion: T	27. Manner of Death  1 Natural 5 Pendi	28a. Date of Injury	28b. Time of Injury	of 28c. Ini	ury at ork? □Yes 2 □ No		how injury occurred			
Division of Vital	Attan r deat ector: by the	Certification: To	3 ☐ Suicide 6 ☐ Could		l nome, farm, st <i>ify)</i>	treet, factory, office		on (Street and Number or Rural Route Number, Town, State)				
	the Hospital or hin 24 hours afte the Funeral Dir mpletely filled in	Medical (	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the best of my kn il Examiner: On the basis of examin and manner stated.	nowledge, dea nation and/or i	th occurred at the investigation, in m	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)		
	To the within 2 To the complete	Ň	29b. Signature and the of certific	Hawk m	6	29c, Lice	nse number 00224	£3	January a  One of the signed (Mon.  One of the	th, Day, Year)		
R	4		30. Name and address of person	acolumn 305	em 23a) (Type 6 Nos	print) D.	n. Chi	n Burne	e mb a	106/		
	St Regist	ate rar	31. Date filed (Month, Day, Year	) 32. Registrar's Sign	nature					,		

		State of Maryland	•	irtment of He ctificate of D		,	200	0 01.206	
		Registrar  1. Decedent's Name (First, Middle, Last)		tinoate of E	- Call	2. Date of Dea			
Physic		VterLino Hersch				Month Jan.	Day Year 20		
/Med Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De		
an and		200 Third St.			eake City		Ceci		
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h 9. E	irthplace (State or Foreign Country)	
Director		212-10-9011 14 92 92  Usual Residence of Decedent 92	+			Oct. 20	7, 1914	Maryland	
yland			Town or Lo	cation				10d. Inside City Limits	
e Mar ka-fst	ctor	Maryland Cecil Che	esapea	ake City				1 X Yes 2 No	
iff the	Director	10e. Street and Number		10f. Zip Code	_		10g. Citizen of What	Country?	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ant, the Medical Evansian results notified at	Funeral	200 Third St., P.O. Box 520  11 Marital Status 12. Was Decedent Ever in U.S.	12.1	219:		anifu Van ar Na	USA	nerican Indian,	
ter de	F	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No	13. 1	Was Decedent of His f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Wi		
urs af	b	3 ¼ Widowed 4 ☐ Divorced Year or Dates:	1	I∐Yes 2∭XNo	Specify:		Specify:	√hite	
5-0	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ient's Usual Occupa	ition uring most of work	ina	16b. Kind of Busines	s/Industry	
han "ithin	ם	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done do OO NOT use retired)	9	9	m 1 *		
Hygie Ther th		12 17. Father's Name (First, Middle, Last)	Truck	Driver	18 Mother's Name	e (First, Middle,	Trucking Maiden Surname)	2	
and d be f ental ced of	o Be	John Raymond Hersch				Walbert			
Maryland 21215-003 d 2 should be filed within 72 hours a lth and Mental Hygiene. 27 Is marked other than "natura"; or traumatic event, the Medical Exa	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	nd Number or Rui	al Route Numbe	er, City or Town, State	, Zip Code) 21915	
Mc 2 Is a train	1	Dorothea Rae Kiszenia/Daughter	200	Third St	., P.O. H	3ox 520,	Chesapeal	ke City, MD	
Dre, Maryland 21215-0036 set 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show rether traumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the Medical Evan had not a built of the staumatic event, the staumatic event, the Medical Evan had not event events and the staumatic event, the staumatic event event event.		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State	ce of Dispo netery, cren	sition (Name of natory or other place	9)	Date	20c. Location - City	or Town, State	
Pages ment of ant: If its				Cemetery		-2009	Chesapeak	e City, MD	
Baltimore, permit. Pages 1 an Department of Hea Important: If item; any Injury or other once.		21. Signature of Funeral Service Lir. min.	l R	Name and Addres T. Foard	Funeral	Home, P	City, MD	21915	
		23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failupe. List only one cause on each line.						Approximate Interval Between	
Physician		Impediate Cause (Findisease or condition MPT STATIC POSTATE CANCER							
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ted isit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	nce of):						
executer and al-tran	xan	that initiated events resulting in death) Last C	nce of):		· · · · · · · · · · · · · · · · · · ·				
18760, icate be executed physician and the burial-transit	dical	d.							
68 rtificat ng phy as th	ledi								
. Box 6 death certifi e attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d		Ectopic pregnancy			23d. Date of	,	
	Sici	in the past 12 months?  1   Yes   2   No   4   Pregnant at time of deal of the past 12 months?  9   Unknown   9   Unknown		Other (specify)			Month	Day Year	
P.C		Part II. Other significant conditions contributing to death but not resulti	ing in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?	
cords, P.O.  w requires that the d been signed by the should be detached	d by		•	od Ventic		ye 1□1	res 2 No 3□	Probably 4 Unknown	
v requirements	Completed	Upinal Plenosis				24a. Was	an 24h Were	autopsy findings available	
Re far he far e has	d m	- DIMAC ( WING )				autop perfo	prior t rmed? prior t death	o completion of cause of ?	
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f V nysici nis ce direc	O B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatier	nt 3 DOA Othe	r.	1	dence 6 ☐ Other (S	pecify)	
ng Pt ng Pt after th	Ë	27. Manner of Death 28a. Date of Injury 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	8b. Time of Injury	Work	at ?	28d. Describe I	now injury occurred		
SiO teath. tor: /	cati	2 Accident investigation			′es 2□No	00/ 1 1/ 1/-			
Division of Vital Records, for Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be d	Certification: To	4 ☐ Homicide  286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  287. Location (Street and Number or Rural Route							
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 Certifying Physician: To the best of my knowl	ledge, deat	h occurred at the tim	ne, date and place	, and due to the	cause(s) and manner	as stated.	
n 24 h	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	on and/or in	vestigation, in my op	oinion, death occur	red at the time,	date and place, and c	ue to the cause(s)	
To the To the comp	×	29b. Signature and title of certifier		29c, License	number		29d. Date signed (Mo	nth, Day, Year)	
		Vity be mel 1		10003	3510		JANUANY 2	8 2009	
U		30. Name and address of person who completed cause of death (Item 2	23a) (Type,	Print)	, ,	/	λ .	10.700	
	tate	31. Date filed (Month, Day, Year) A2. Registrar's Signatu	1 32 re	14 Uples 1	1th N	DWA K,	DUWNY	14702	
Regis		30. Name and address of person who completed cause of death (Item 2) in the complete c	par	2					

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician January 2009 11:20 P M Christine Howes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Julia Manor Health Care Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Columbia District of 5. Social Security Number 8. Date of Birth (Month, Day, Year)
May 27, 19 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🗓 F 577-54-9879 71 1937 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Event in the Intifficial anonee. 1 X Yes 2 ☐ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U.S.A. 313 Mitchell Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgette King Wilson Dodson ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12622 Hazel River Rd., Rixeyville, VA James Duncan/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) rk. 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial 1/31/2009 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last a consequence of Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Vear Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 Devio has page 2 1 ☐ Yes 2 X No certificate ours after death.

Interpretation After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year

32. Re

the Hospital or Attending Physician; The law requires that the death certificate be within 2 To the I

Medical

State Registrar

Melissa Brassell, MD 31. Date filed (Month, Day, Year)\_

29b. Signature and title of certifier

Assistant Medical Examiner Registrar's Signature **ORIGINAL**  29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 6, 2009

and manner stated

Branel 30. Name and address of person who completed cause of death (Item 23a)

Division of Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after or To the Funeral Direct completely filled in by Hospital

	.,,,	I Denipation 2	Elizoutpationi of		THOME SET	ione of residence of other (openly)				
27. Manner of Deat 1 Matural 2 Accident	h 5  Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fa	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and	title of cortifier			29c. License number	29d. Date signed (Month, Day, Year)					

OLAIDE AJAMI, M.D

D0066606 February 7,2009

ECD 1 9 1000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLAIDE AJAYI, M.D. 900 SETON DR. Cumber and MD 21502 31. Date filed (Month, Day, Year) 32 Registrar's Signature

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State

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4, Claudia Anne Hudson February 2009 6:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 30045 Huntt Road Mechanicsville St. Mary's Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 😿 F Director 213-40-9696 Dec. 27, 1942 Washington, DC 66 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 28a-f Mechanicsville Maryland St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 23a 20659 30045 Huntt Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other traumation. 12 Bus Driver Charles County Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbe Moler Curtis Mary ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John M. Hudson/ Spouse 30045 Huntt Road, Mechanicsville, MD 20659 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Queen of Peace 02/11/2009 Helen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SINAS Mina disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and burial-trar Due to (o) as a consequence of) Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) o. the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should b Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) te Hospital or Attending Pl n 24 hours after death. te Funeral Director: After ti 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Qay, Year) cause of death (Item 23a) (Type dress of person vho comp 31. Date filed (Month, Day, 32. Registrar's Signature Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0:30 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Nursing Home Clinton PG If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 04/13/1926 **Funeral** Hours Min. Months 1 √ M 2 □ F Davs 218-18-9614 82 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d Inside City Limits event, the Medical Examiner must be notified at Director MD PGClinton 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 20735 9211 Stuart Lane items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Tyyes 2 No If Yes, Give Year or Dates: **49**–**50** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: ģ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Johnson Dora Briscoe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Julian Johnson -16403 Rolling Tree Road; Accokeek, MD 20607 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National Cem. 01/28/2009 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 4594 Beech Road; Temple Hills, Maryland 20748 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only on cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) O. Box 68760, physician the burial Physician/Medical attending p for use as 1 as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division To the Hospita ... within 24 hours after death.
To the Funeral Director: Aftrownletely filled in by the fur 1 - Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical nd title of certif 29b. Signature 29d. Date signed (Month, Day, Year) NURG 227/09

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

32. Registrar's Signature

7. Age (In yrs. last birthday)

10c. City, Town or Location

LEONARDTOWN

79

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

Leonardtown

Months Days

10f. Zip Code

3. Time of Death

1:50

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 No

1929 NORTH CAROLINA

4c. County of Death

10g. Citizen of What Country?

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🏻 No

Year

St. Mary's

January

8. Date of Birth (Month, Day, Yea MARCH 19

A M

**Physician** /Medical Examiner

**Funeral** 

1 - State Registrar

10a. State

Thomas Jenkins

5. Social Security Number

237-46-1400 Usual Residence of Decedent

MD

10e. Street and Number

4a. Facility Name (If not institution, give street and number)

St. Mary's Nursing Center

ST. MARY'S

10b. County

6. Sex

1 → M 2 □ F

Director 28a-f show the Medical Exercitive must be notified at ŏ 23a ō "natural",

Funeral within 72 hours after Baltimore, Maryland 21215-0036 ş Completed filed withir Hygiene. other than 3rd 2 should be find and Mental H Be es 1 and 2 should b of Health and Ment f item 27 is marked r other traumatic e ဂ္ Pages ment of permit. Pages Department of Important: If it any Injury or o Physician disease or condition resulting in death) /Medical Examiner Examine sician and burial-transit The law requires that the death certificate be executed attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: i signed by the a d be detached fo P.O. 9 Unknown Records, þ icate has been si Completed To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page of Vital Be 27. Manner of Death Certification: Division 1 Matural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier

Director 21685 JOE HAZEL ROAD 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes 2 \_\_XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: BLACK Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLERK MANAGER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KING SOLOMON JENKINS LUCY BAILEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA FRAZIER/DAUGHTER 21685 JOE HAZEL ROAD LEONARDTOWN, MARYLAND 20650 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 1/30/2009 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME So stude of Fun all Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Due to (or as a if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conse resulting in death) Last Due to (or as a consequence of 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed' 1 ∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) **JAMES** PATRICK JABOE M.D. 240235 THREE NOTCH ROAD HOLLYWOOD, MARYLAND 20636 31. Date filed (Month

State Registrar

			State of Maryland / Departm	nent of He cate of D	ealth and Mei	ntal Hygien	2009	04213			
			Registrar  1. Decedent's Name (First, Middle, Last)	Jale Of D		Reg. N Date of Death	0.	3. Time of Death			
	Physicia		David E. Jones				ay Year	12:55 A M			
*	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. 0	City, Town, or I	Location of Death		c. County of Death				
					shington If Under 24 Hrs. 8	P Date of Birth	rince Ge				
	Funeral Director			nths Days	Hours Min.	(Month, Day, Yea	r) Coi	nplace (State or Foreign untry)			
	D		Usual Residence of Decedent		re	b 9, 195	5 Sout	h Carolina			
	arytar show	'n	10a. State   10b. County   10c. City, Town or Location   Maryland   Prince George's   Fort Washin					10d. Inside City Limits  1√√√Yes 2 No			
	the M 28a-f	Director	Maryland Prince George's Fort Washin  10e. Street and Number	f. Zip Code		10a. C	itizen of What Co				
	3a or	iO le	1510 Taylor Avenue 2	20744			nited Sta	•			
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Diff Yes,		spanic Origin? (Specify n, Mexican, Puerto Ric		14. Race - Amer	ican Indian.			
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any filury or other traumatic event, the Medical Examiner must be notified at ance.	by Fu		es 20 No	Specify:	- ' - '		American			
3-003p	2 hour	ted t	15. Decedent's Education 16a. Decedent's			16b.	Kind of Business/I				
מ	a. an "n Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  4 College (1-4or 5+)  Year's  (Give kind of life. DO NO	OT use retired)	uring most of working			·			
7	led will fygien her th				40 M-45-3- N (F		overnment	t (USAF)			
yland	uld be fil fental H rked ott	Be			18. Mother's Name (F		en Surname)				
Ξ.	should I	우		dress (Street a	Lila M.  nd Number or Rural R		or Town, State, Z	(ip Code)			
Ma	alth a		Cornell L. Jones, Jr Brother 1510 T	aylor A	Avenue For	t Washin	gton, MD	20744			
ore	les 1 and 2 of Health if item 27 i		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ Removal from State	(Name of y or other place			Location - City or	Town, State			
Saitimor	tment of I tant: If ite		P☐Donation 5☐Other (Specify) Lee's Cremat		Jan 28,		Clinton,				
Da	permil Depar Impor any in			ne and Address . B <b>enni</b> r	<sup>s of Facility</sup> Ster ng Road, Ni		eral Home eton, DC	•			
li	i e	Ţ	23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Ÿ	Physician		Immediate Cause (Final disease or condition resulting in death)  Human Immunodeficie	ncy Vi	rus			Onset and Death			
	/Medical Examiner		Due to (or as a consequence of):	C . 1	<b>D</b> .						
		Jer									
	ecuted nd transit	Examin	Cause. Clisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
8/60,	icate be executed physician and s the burial-transit										
200	ficate physis the	edical	d								
XOD	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □Ectop	pic pregnancy			23d. Date of deli	very			
ם כ	e deat he att	sicis	in the past 12 months?  1 ☐ Yes 2 ☐ SNo 9 ☐ Unknown  1 ☐ Unknown	er (specify)			Month	Day Year			
J.	that the ed by the detache										
ďs,	w requires that the death certif been signed by the attending should ba detached for use as	d by		3 3				the cause of death?  obably 4  Unknown			
ecord	0 0 0	Completed			_	24a. Was an	24b. Were au	topsy findings available			
r	sician: The lew certificate has I rector, page 2 s	mo.				autopsy performed? 1□ Yes 2 •••••••••••••••••••••••••••••••••••	death?	completion of cause of 2 ☐ No			
VITa	clan: ertific ector,	Be C	25. Was case referred to medical examiner?	T	26. Place of Death (C	A					
0	o is.	ဥ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Othe	4 Li Nuising nome			cify)			
Sion	ding After fune	tion	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation M	28c. Injury Work′ 1	rai ? /es 2 □ No	. Describe now in	cribe how injury occurred				
<u> S</u>	Atter or deal ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	actory, office	28f	Location (Street of City or Town, Sta	and Number or Ru	ral Route Number,			
5	ital or irs afte ral Dii	Cert					·				
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occur of the basis of examination and/or investigated and manner stated.	urred at the tim jation, in my or	ne, date and place, and pinion, death occurred	I due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)			
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License	number	29d. E	ate signed (Montl	n, Day, Year)			
	_		og structor of		0665		01/26	109			
)	5		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	SIL Pr	11PL#20	0 100	C MD	nonkl			
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	41 6		V KANC	V I'IV	W117			
Ĺ	Registi	ar	JAN 2 8 2009 Cenera D. Janes								

			T - State Registrar			Cer	tificate	of D	eath			Reg. No.				
			1. Decedent's Name (First, Middle	e, Last)						:	2. Date of De Month	eath Day	Year	3. Time	of Death	
	Physicia /Medic		Florence	Μ.	M. Johnson									04:	35 <sup>M</sup>	
7	Examin		4a. Facility Name (If not institution	ımber)	4b. City, Town, or Location of Death						4c. County of Death					
			9603 Beach	wood Ave	€.		Lanham			Prince Ge			eorg	es		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖫 F	7. Age (In yrs.		If Under 1 \	ear ays	If Under Hours	24 Hrs. (	Month, D	rth a <i>y</i> , Yea <i>r)</i>	9. Birth Cou	place (State ntry)	e or Foreign	
ı	Director	1	579-24-4923		98	Yrs.					May 1	, 19	10 Was	hingt	ton, I	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Loc	cation							10d. Inside	City Limits	
	Aaryl sho	ō	Md. Monto	omery	Si	lver S	Spring	7						1 🗆 Y e	es 2X No	
	the A	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co							en of What Cou	ntry?					
	with	ā	13938 Alderton Rd. 20906						U.S		, .					
	leath	by Funeral	11. Marital Status		cedent Ever in U	J.S. 13. V	Vas Deceden Yes, specify	t of Hisp	panic Ori	gin? (Spec	ify Yes or N	0- 14	4. Race - Ameri	can Indian,		
· _	r iter	ᇤ	1 ☐ Never Married 2 ☐ Marr	Armed F ned 1 ∐ Yes	2X No						ican, etc.)		Black, White,			
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-f show he Moulcal Exaculturer, use be notified at	δ	3 ☐ Widowed 4 🙀 Divorced	If Yes, G Year or I	ive Dates:	1	☐ Yes 200	No	Specify:			5	Specify: B]	ack		
9	72 ho	Completed	15. Deceden (Specify only highe	t's Education	)	16a. Deced	lent's Usual C	ccupati	on ring mos	t of working	7	16b. Kin	d of Business/Ir	dustry		
2	thin .	ld l	Elementary/Secondary (0-12)		(1-4or 5+)	life. C	O NOT use	etired)	mig 1/103	t or working	•	Co		- +		
2	filed wi Hygien other th	ő	12			Cle	rk							ernment		
2	d oth	Be	17. Father's Name (First, Middle,	Miles	_			1			ne (First, Middle, Maiden Surname)  Cook					
<u> </u>	Meni Meni arke	2	Thomas		5				Co							
ā	2 sh and ts m		19a. Informant's Name/Relations				-						Town, State, Zi			
2	and ealth m 27		Gertrude Byr	d/ daugi		_						_	ring,M		0906	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Modical Examinat class be notified at once.		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Removal from	State	Place of Dispos cemetery, cren	sition (Name natory or othe	of r place)	1	Da	10	20c. Loc	ation - City or T	own, State		
Baltimore,	men tant:		4 Donation 5 Other (S	A	Li	ncoln					/2009		itland			
3a	permit Depar Impor Impor Eny in		21. Signalure Funeral Service	Licensee -									rtuary			
	005 a 0		Lawy	1 V SIVE W	<i>~</i>								hingto			
T			23a. Part I. Enter the disease; or shock, or heart failure. List	only one cause on	caused the dea each line.	th. Do not ente	er the mode o	t dying,	such as	cardiac or	respiratory a	arrest,		Approxim Interval B Onset an	etween	
7	Physician		Immediate Cause (Final disease or condition A Hypertension													
	/Medical Examiner		resulting in death)		(or as a conse											
Н	Examine	_	Sequentially list conditions,		erebro		ar Ac	cio	lent							
	ed sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quanca oi).										
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68760,	certificate be executed Iding physician and Ise as the burial-transit	/Medical		d					-							
×	certif nding ise a	/We	IF FEMALE:	23c. If yes, or	utcome of pregn	ancy						2.	3d. Date of deliv	env		
ă	atter for L	Iclar	23b. Was decedent pregnant in the past 12 months?  1							Month			Day Year			
P. O.	y the	Physi	1 ∐ Yes 2 MaNo 9 ∐ Unknown	9 Unknown												
	The law requires that the death Ite has been signed by the atter bage 2 should be detached for u	y Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part								23e. Did	tobacco us	he cause o	f death?		
g	quires n sign	d by									10	Yes 2 🛚	No 3□Pro	bably 4 [	⊒Unknown	
8	Short	Completed									24a. Wa	san	24b. Were auto	opsy finding	s available	
æ	The law cate has	E										omed?	prior to co death?	emptetion of	cause of	
<u>a</u>		Č	25. Was case referred to medica	t					S Place	of Death	1 ☐ Yes (Check only		1 🗆 Yes	2 🔯 No		
Division of Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	TER/Outpatien	t 3 DOA	Other:			e 5 ☐ Res		XOther (Speci		giver's	
0	g Phy er thi		27. Manner of Death	28a. Date	of Injury	28b. Time of		Injury a Work?					ury occurred			
<u></u>	ndin ath. r: Aft	atlo	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	ig .	nth, Day Year)	Injury	м		s 2 🗆	No						
<u>N</u>	Atte octo by th	1	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Plac	e of Injury - At h		eet, factory, o	ffice		28	3f. Location	(Street and	reet and Number or Rural Route Number,			
Ö	s afte	Certification;	4 I Holliede	Dun	ding, etc. (Speci	ny)					City of Te	iwii, Sialej				
	To the Hospitat or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 ☆ Cartifyii	ng Physician: To the	ne best of my kn	owledge, death	occurred at	the time.	, date an	d place, ar	nd due to the	cause(s) a	and manner as s	stated.	. (0)	
	he H in 24 he F plete	edical	one)	and ma	nner stated.	ation and/or inv	estigation, in	my opir	non, dea	un occurre	at the time	, date and p	piace, and due t	o trie cause	)(S)	
	To t To t	Σ	29b. Signature and title of certifie	1/1			29c. L	icense r	number	2		29d. Date	signed (Month,	Day, Year	। क	
)			MINU	100			ノーケ	45	Do			/	-23	-09		
2	2		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type,	Print)	~ /		"/0	11 -	4.1	1 - 1 - 1 1	67	474	
	<u> </u>		WILLAMK		rick!	U6 + R	VING	31	. N.	W S	# 301	+ W4	ASH. DC	hoc	10	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 8 2009	32.	Registrar's Sign	ature										
3	riegisti	- CII	JAN & O LOUS	come	19. 196	West										

State of Maryland / Department of Health and Mental Hygien 👂 \right \right 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 26, 2009 550 A **Blanche** Kramer <u>January</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. September 7,1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 577-20-0921 87 MA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 √ Yes 2 No Director MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 20902 1121 University Blvd #719 United States Iteme 23a death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after ☐Yes 2 X No 1 Never Married 2 Married White 1 Yes 2 No ö Baltimore, Maryland 21215-0036 Specify: Specify 3 Nidowed 4 Divorced Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary US Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth any fujury or other traumatic event appra. Be Morris Rodman Rose Brodsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ian Kramer - Nephew 10316 Holly Hill Place Potomac MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Mem. Gardens 1/30/09 Olney, MD 21. Signature of Funeral S 22. Name and Address of Facility vice Licensee Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Sepsis /Medical Due to (or as a consequence of): Examiner Perineal Azotemia Sequentially list conditions, if any, leading to inmodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use es the burial-transit Hypernatremia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Atrial Fibrilation IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an autopsy performed?
1 Yes 24 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 X No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 v Inpatient 2 ER/Outpatient 3 DOA this s after death.
I Director: After this
id in by the funeral d 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medicai Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funarel C Hospital 1 Certifying Physician: To the best of my knowledge death-occurred at the time date and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1-26-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forest glew rd Silver 5/2mg/mp 20910. AHMIED NAWA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 17:15 M William Lewis January 21,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F 577-58-7960 65 **Director** 4/4/1943 Unknown Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show my lury or other traumetic event, the Modical Examinar must be neitlined anonce. 1 X Yes 2 No Director DC Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 541 Shepherd Street N.W. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown ဂ္ 19a. Informant's Name/Relationship (Type. Print) Irene Hudson/Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 1/27/09 Riverdale, MD 21. Signature of Surreral Service Licensee 22. Name and Address of Facility Austin ROyster Funeral Home 3821 14th Street,NW,Washington,DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** noa /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Box 68760, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death cate has been signed by the etter page 2 should be detached for u 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical

P.O. of Vital Records, filled in by the funeral director, Division 24 hours after deat Funeral Director: completely within 2.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 1600 January 22, 2009 who completed cause of death (tem 23a) (Type, Print) 615 32 Registrar's Signature **ORIGINAL** 

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of celtifie

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 State Registrar Amend#26. PerPhys. PGC1-28-09cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year MARY ONG **Physician** 0838 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's 13504 Gulliver's Trail Bowie 8. Date of Birth (Month, Day, April 24, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□M 2ØF Months Days Hours Min. Virginia 578-22-4527 88 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c City, Town or Location 10a. State 10h County ral", or Items 23a or 28a-f show Examiner must be notified at **Bowie Funeral Director** MD Prince George's TXT]Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20720 U.S. 13504 Gulliver's Trail 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married African-American Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify. If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Hare **Administrator** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thamas Long Elizabeth Turner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13504 Gulliver's Trail, Bowie, MD 20720 Pauline Wayne-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-28-09 Winston, Virginia Rising Zian Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lieensee Bornette & Assoc. Funeral Home 2504 28th St., N.E., WDC 20018 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EREBRO VASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23h. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No of Vital 1 ☐ Yes 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence of Other (Specify) 1□Yes 2⊅No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by determined 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title, of certifier

State Registrar 31. Date filed (Month

EFENSE

political cause of death (Item 23a) (Type, Print)

aren A. Sherrill'L	1	on State o	f Maryland / Depart Certi		Health a		Hygiene	200	9 0421
Physiciar	1/	egistrar I. Decedent's Name (First, Middle,Last)					2. Date of Death		3. Time of Death 0259 hrs
Medical Examin		a. Facility Name (if not institution, give	Karen A. She			n, or Location of De	Month January 26	, 2009 4c. County of Death	
· .		10810 Southall Drive			Upper M	- 2	.:	Prince George	
Funeral Director		5. Social Security Number 6. Sex 245-11-1712 1	7. Age (In yrs. lasi	birthday) Yrs			Hrs. 8. Date of Birth Min. May 31	(MM/DD/YYYY) 9. Bir Foreig 1963	thplace (State or Washington DC
/land -f show any once.		Usual Residence of Decedent 10a. State 10b. County  Maryland Prince G		own or Locat	Uppe	r Marlbo			10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho potified at once.	i E	10e. Street and Number 10810 Southall Dr	ive		10f. Zip Cod	0774	10,	g. Citizen of What Cou USA	ntry?
er death wi	Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No f Yes. Give Year	If Y	es, specify Cu	f Hispanic Origin?  uban, Mexican, Pue  No specify:	( Specify Yes or No- erto Rican, etc.)	White, etc.	ican Indian, Black,
hours aft	ted by	15. Decedent's Education (Specify only  Elementary/Secondary (0-12)	or Dates:	6a. Deceder	nt's Usual Occ	upation (Give kind glife. DO NOT use		16b. Kind of Business/	lack Industry
5-0036 iled within 72 Hygiene.	$\sim$ 1	17. Father's Name (First, Middle, Last)	4+	Regi	stered		ame (First, Middle, M		rment
21215-( 21215-( Mental Hygin marked oth	e Be	Warrenn She		19b. Mailin	g Address (S	Street and Number	Jacquelin	ne Ponds per, City or Town, State	e. Zip Code)
e, MD 2 I and 2 shou Health and N item 27 is n r traumatic	ို	<sup>19</sup> Informant's Name/Relationship (Ty Keon Lofton (S Kirkland Lofton J	on) & r. (Son)					arlboro MD	
More, N Pages I and itent of Health		20a. Method of Disposition  1 X Burial 2 Cremation 3		ace of Disposematory or ot	sition (Name o her place)	of cemetery,	Date	20c. Location - City of	Town, State
Baltimore, permit, Pages I ar Department of Her Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	Ft.		In Ceme	5 m - 100		Brentwood	
Ba Perm Depa Tinjur	4	fatricia L	atimore	9	013 An	napolis I	Road, Lanh	am MD 2070	vices, P.A.
Physician /Medical caminer		or condition resulting in death)  Sequentially list conditions,		s	пе тове от ву	ying, such as cardi	ac or respiratory arre	st, Shock, of Heart	Approximate Interval Between Onset and Death
xecuted n and - transit	Examine	(Disease or injury that initiated C	ue to (or as a consequence of):						
a a a	dical	UNPENDED	AMENDED						
Division of Vital Records, P.O. Box 68760, the Ilospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physicin physicin physicin physicin physicin physicin by the funeral director, page 2 should be detached for use as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unknown	23c. If yes, outcome of pregnation Live birth Pregnant at time of dear Unknown	2 F6	etal death ther (Specify)	3 Ectopic pre	egnancy	23d, Date of deliver Month	ry Day Year
, P.O. B res that the d signed by the be detached	2	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cau	use given in Part I.		bacco use contribute to	the cause of death?
Division of Vital Records, P.O. In to Attending Physician: The law requires that the rs after death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed				00.5		24a. Was a autops perfor	sy prior to med? death?	utopsy findings available completion of cause of es 2 No
Vital hysician this certi	To Be	25. Was case referred to medical examiner?  1 Very 2 No	ospital: 1 Inpatient 2 E	R/Outpatien		Other No		Residence 6 🗸 Othe	er: Scene
on of cading Ph		27. Manner of Death  1 Natural 5 Pending	FOUND:	28b. Time of FOUND: 0236 hrs	Injury 28c.	. Injury at Work? Yes 2 ✔ No	Subject shot	ow injury occurred	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor (Specify) Residence	ne, farm, stre			or Town, Si 10810 Southa	ate) Il Drive, Upper Marlt	
To the Hos within 24 h To the Fun completely	Medical (	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and	e, death occu d/or investiga	irred at the timation, in my op	ne, date and place, sinion, death occurr	and due to the cause red at the time, date a	e(s) and manner as sta and place, and due to t	ited. he cause(s)
To with To com	Mec	29b. Signature and title of certifier	and manner stated.			cense number		29d. Date signed (M	
		Poti () -	Holleda	NO	0	D.C.M.E.		January 26, 200	9
R 10		<ol> <li>Name and address of person who c Patricia Aronica-Pollak MD</li> </ol>	. Assistant Medical E	xaminer	111 Penr	n Street, Baltir	nore, MD 21201		
Sta Registr	ite	31. Date filed (Month, Day Year)	32. Registrar's Signatu						

DHMH 17 Rev 1/2001 OCME 2006

09-00765 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Karissa Lofton 04219 2009 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 26, 2009 0302 hrs Medical Examiner Karissa Lofton 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Prince George's Upper Marlborg 10810 Southall Drive 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or ForeignWashington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Linder 24Hrs **Funeral** Days Director M 2 XF Country) 16 213-35-7805 Feb 18 1992 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 1 XYes 2 No or items 23a or 28a-f show must be notified at once, Maryland Prince George's Upper Marlboro Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10810 Southall Drive 20774 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. after death 1 X Never Married X No Yes Specify: Black If Yes, Give Yee Widowed Δ Divorced Yes 2X No specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 partment of Health and Mental Hygiene. portant: If item 27 is marked other than ' ury or other traumatic event, the Medical Baltimore, MD 21215-0036 Pages I and 2 should be filed within; nent of Health and Mental Hygiene. Student Private 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karen Sherrill Kirkland Lofton, Sr 19a. Informant's Name/Relationship (Type, Print Kirkland Tofton, Jr. ( 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10810 Southall Drive, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/31/2009 Brentwood, MD Lincoln Cemetery Ft. Donation 5 Other Specify 22 Name and Address of Facility Latimore Funeral Services, P.A. 21. Signature of Funeral Service License atimore 9013 Annapolis Road, Lanham MD 20706 Approximate Interval 23a, Part I. Enter the dise. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** Between Onset and failure. List only one cause on each line /Medical Death Gunshot Wounds (2) of Head and Neck Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. cal ysician a UNPENDED **AMENDED** Physician/Medi Box 68760. 23d. Date of delivery phy: IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. \$ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate h Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Hospital: 1 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 this ۲ 1 V Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot FOUND: Natural Yes 2 ✔ No Pending e Funeral Director: etely filled in by the Jan 26, 2009 0236 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 10810 Southall Drive, Upper Marlboro, MD determined (Specify) Residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1

30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner

and manner stated

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 26, 2009

29c. License number

OCME

31. Date filed (Month, Day State Registrar

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month January 27, 9:47 P M ALBERT C. LOWE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8368 Upper Hill Road Westover Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 MM 2□F Director 220-34-2632 03/24/1937 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Somerset Westover 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 8368 Upper Hill Road 21871 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Park & Planning Commis. Plumber permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis E. Lowe Louise Barnhouse ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vera Lowe/Wife 8368 Upper Hill Road, Westover, MD 21871 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Beechwood Cemetery 4 □ Donation 5 □ Other (Specify) 02/01/2009 Princess Anne, MD Signature of Funeral Service Licensee 22 Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853 √ M00295 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 CANCER **Physician** LUNG /Medicai Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, led by the attending physician detached for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 | Inpatient 2 ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral C 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01/28/2009 D 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRISFIELD, MD 21817 HIGHWAY. VIJAY KARUMBUNATHAN HALL 32. Registrar's Signature 31. Date filed (Mont) State

DHMH 17 Rev 1/2001

Registrar

			For State	State of Ma	arylan		artment of H		ıd Mer	ntal Hy	giene			
	5		Registrar  1. Decedent's Name (First, Midd	llo ( act)	Cei	rtificate of l	Jeath	1 2	Date of Dea	Reg. No.	2009	9	04221	
	Physici /Medic		Patrick	Arms	stron	g	Murphy		J	Month Anuary	26, Day			1:10 А м
	Examin	er	4a. Facility Name (If not institution  Ft. Washington Ho				4b. City, Town, or Ft. Washi		Death		1	County of Dea		te
	Funeral		5. Social Security Number		e (In yrs. I	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8.	Date of Birt	b	O Di	rthplac	e (State or Foreign
	Director		233-34-4784	XXXM 2□F 8	4	Yrs.	Months Days	Hours I	Min. J	(Month, Day	y, Year) , 1924	4   W	ountry est	Virginia
	pu ,		Usual Residence of Decedent  10a, State 10b, County	,	10c City	, Town or Lo	cation						104	Inside City Limits
	faryla shov	or		e George's		Temple							100.	1 ☐ Yes 2 🛣 No
	the N	rect	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What C	ountry	?
	h with	al Di	5005 Shopton Driv	<i>r</i> e			20748					USA		
	ems 2	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	S. 13.1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin n, Mexican, P	? (Specify	/ Yes or No- an, etc.)	-	14. Race - Am Black, Whi		
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 □ Mar 3XXWidowed 4 □ Divorced	If Yes, Give	W II		1 ☐ Yes 2123 No	Specify:				Specify: W		
Ş	hour tural	ed b		nt's Education		16a. Dece	dent's Usual Occupa	ation			16b. Kir	nd of Business	s/Indus	trv
215	hin 72 s. an "ne Medk	Completed	(Specify only highe	est grade completed)  College (1-4or 5	i+)	(Give	kind of work done on QO NOT use retired	during most of ')	f working	1		Construc		
21	yd with	Com	Elementary/Secondary (0-12)		.,	neavy	Equipment C	perator				WISH UC		
ng	be od o	Be	17. Father's Name (First, Middle	_				18. Mother's		irst, Middle, Amstro		Surname)		
<u> </u>	hould d Mer marke matic	ည	Frank Murr			10h Mailir	ng Address (Street a	Art				Town State	Zin Co	nda)
Z Z	₽ £ ₩ ₽		Patricia Murphy				E. Taylor S				_		Zip Oc	ide)
re,	ages 1 and 2 nt of Health : If Item 27 I or other tra		20a. Method of Disposition		20b. P		sition (Name of matory or other place		Date			cation - City o	r Town	, State
E	Pages nent of I ant: If Ite ury or o		1 ☐ Buria! 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (		1	las Cren			n. 28,	,2009	Edge	water, M	ary1	and
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Ligensee	•	22	2. Name and Addres	ss of Facility Ii 11 Road	Geor 1 Oxon	ge P. I Hill,	Kalas Mary	Funeral land	Hon 2074	
	Name I		23a. Pa t. En r the disease, o shock, or heart failure. Lis	r complications that caused	the death	n. Do not ent	er the mode of dyin	g, such as car	rdiac or re	espiratory ar	rest,		A	oproximate terval Between
	Physician		Immediate Cause (Final disease or condition	_a. CARDII			_						ö	nset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):								
	- Adminier	-	Sequentially list conditions,	b. PN EUM Due to (or as										
	uted f ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 . HYPOT		,	im							
oʻ	exection and and rial-tra	Еха	resulting in death) Last	Due to (or as	a consequ	ence of):								
8760	icate be executed physician and s the burial-transit	dical		La KIDNE	YF	AILU	RE					_		
Box 6	the death certific y the attending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	3d. Date of de	elivery	•
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			∃Ectopic pregnancy ∃Other (s <i>pecify)</i>					Month	Da	y Year
О	at the by th	hys	9 🗆 Unknown	9□Unknown					1					
	w requires that the de been signed by the s should be detached	by	Part II. Other significant condit		ut not resu	ılting in the uı	nderlying cause give	en in Part I.		23e. Did to				cause of death?
Ö	requi	eted			201				_					y 4X\(\tag{Unknown}\)
Vital Records,	sician: The law requires that certificate has been signed by irector, page 2 should be deta	Completed	CONC.	TARY HEMO	1CICU	HACKE	UK-	UBCIA.	5( A		rmed?	prior to death?	compl	findings available etion of cause of
<u>ra</u>		a)	25. Was case referred to medica		7 1	MICO	ice	26. Place of	Death (C	1☐ Yes	2XIXI No	1 ☐ Ye	s 2[	□ No
	> 07 73	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 X Inpatie	nt 2 🗆 I	ER/Outpatier	nt 3 DOA Othe	or.				3 □Other (Spe	ecify)	
0	ulng Ph		27. Manner of Death 1 Natural 5 □ Pendi	28a. Date of Inju (Month, Day	ry v Year)	28b. Time of Injury	f 28c. Injun Worl	y at k?	28d	. Describe h	now injury	occurred		
<u> </u>	ttendl feath. tor: A	cation	2 Accident invest 3 Suicide 6 Could	tigation	44 h.a	farm str		Yes 2 □ No		1 1 10	24	d Atomic and Comme		
Division or	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	4 ☐ Homicide detern	mined 286. Place of injuries	c. (Specify	me, iarm, str	eet, factory, office		281.	City or Tou		d Number or Fi	iurai H	oute Number,
	ospita nours ineral y filled		29a. Certifler 1 Certifyi	ing Physician: To the best	of my know	wledge, deatl	h occurred at the tin	ne, date and p	olace, and	due to the	cause(s)	and manner a	s state	d.
	the Ho iin 24 the Fu	Medical	one)	I Examiner: On the basis of and manner sta	t examinat ated.	tion and/or in			occurred	at the time,	date and	place, and du	ie to th	e cause(s)
		Σ	29b. Signature and title of certific				29c. License				29d. Date	e signed (Mon	th, Day	r, Year)
) ^	12 11		/SUS con			00-) (T		8218			THI	26,	25	09
R	-		30. Name and address of person					PER M	ARL	20/20	M	0 20	75	12
	Sta		31, Date filed (Month, Day, Year		ar's Signa	ture	, 011			<i></i>			•	
	Registr	ar	JAN 2 9 2009	Chrone &	9							_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JÄNUARY 2009 2:19 PM BENJAMIN MAYO JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEROGE'S BOWIE HEALTH CENTER BOWIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5, Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Year) Months Hours 1 € M 2 □ F 239-22-4728 86 1922 SEPT 13 NORTH CAROLINA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1∏Yes 2∏No Directo PRINCE GEROGE'S BOWIE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20716 12507 HEMM PLACE USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or ite mury or other traumatic event, Ite Medical Examina ury or other traumatic event, Ite Medical Examina 1X)Yes 2 □ No ARMY IfYes, Give 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No BLACK Specify: \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th POSTAL CLERK GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN MAYO MARY PRATT ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN D. MAYO/WIFE 12507 HEMM PLACE BOWIE, MARYLAND 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or of 1 □ Burial 2 □ Cremation 3 □ Removal from State LINCON CEMETERY 1/29/2009 4 Donation 5 ☐ Other (Specify) BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed HYPERPARATHYRODISIM and the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria COLON CANCER Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 □Yes 2 □No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) \( 5 \) \( \text{Residence} \) \( 6 \) \( \text{Other} \) (Specify) 1□Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 29a. Certifier 🏗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29d. Date signed (Manth, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) JAN 2 9 2009

1221 MERTANTILE LANE LARGO, MARYLAND 20774 ANITA CLAYTON M.D. 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-00902 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

NN UNN		State of Maryland / D 1-For State Registrar	epartment o <i>Certificate o</i>		id Mental H		g. No. 20	09 0422				
Physicia edical Exami		1. Decedent's Name (First, Middle,Last)  Claudie Moore			19	2. Date of Death Month January 30	1	3. Time of Death 1619 hrs				
Landing Co.		4a. Facility Name (if not institution, give street and number) Prince Georges Hospital		4b. City, Town, or Cheverly	Location of Death	bandary oc	4c. County of De					
Funeral Director		579-54-1747 1XM 2_F 66	yrs. last birthday) Yrs	If Under 1 Year Months Day			h(MM/DD/YYYY) 9.	Birthplace (State or Preign Washington, Country)				
imore, MD 21215-0036  gass 1 and ∠ should be filedutiin 72 hours after death with the Maryland ment of Heath and Ahental Hygiene.  tant: If item 27 is marked offer than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Maryland Prince George's  10e. Street and Number  7407 Crane Place  11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced If Yes, Give Year or Dates.  15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12)  10 years  17. Father's Name (First, Middle, Last)  William Moore  19a. Informant's Name/Relationship (Type, Print)	No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	asant  10f. Zip Code 20785  as Decedent of His Yes, specify Cubai  Yes 2 X No nt's Usual Occupa nost of working life  Janito	spanic Origin? (Sp. n, Mexican, Puerto specify: tition (Give kind of verto) DO NOT use reti  18.Mother's Name Jewe1 et and Number or F	work done red)  (First, Middle, M Solomon Rural Route Numi	White, etc.  Specify:  16b. Kind of Busine  Privat  laiden Surname)  ber, City or Town, S	merican Indian, Black, c. African American ess/Industry				
Baltimore, MD 2 permit Pages 1 and 2 should be partment of Health and N 2 in portant. If iten 27 is in pury or other fraumatic		Signature of Funeral Service Licensee      But a license licensee      Signature of Funeral Service Licens	20b. Place of Dispos crematory or of Harmony Me 22. I	sition (Name of ce ther place) emorial Name and Addres 001 Benn: the mode of dying	Park Feb s of Facility Steing Road, such as cardiac c	7. 2009 ewart Fu NE Was	neral Hom hington. st, shock, or heart	y or Town, State				
y amilier cian and irial - Iransit	dical Examiner	X UNPENDED AMENDED 23a, PII, 27, per ME g888 2/18/09 TT										
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and limeral director, page 2 should be detached for use as the burnal - transit	by Physician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Hypertensive atherosclere	2 Fe of death 5 O	, ,		23e. Did tot 3e 1 Yes 24a. Was a	2 No 3 I	Day Year  e to the cause of death?  Probably 4 ✓ Unknown  e autopsy findings available to completion of cause of				
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Division of To the Hospital or Attending Phywifin 24 hours after death. To the Funeral Director: After templetely filled in by the funeral	Certification:	Suicide Could not be determined (Specific)	28b. Time of - At home, farm, stre	1	yes 2 No			Rural Route Number, City				
To the Hospit within 24 hour To the Funera	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my known 2 Medical Examiner: On the basis of examina										
To with To To COIT	Me	and manner stated.  29b. Signature and title of certifier  W W		29c. Licens			29d. Date signed (					
0		Name and ad ress of person who completed cause of death     Ling Li, MD	111 Penn Stree		MD 21201			0/1				
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's S	parle	1								

	For State Registrar	State of Mar		artment of H tificate of L		Mental Hy	giene Reg. No.20	09 04	224		
Physician /Medical Examiner	Joseph Ri	chard M	lcLaughlin	4b. City, Town, or	Location of Deat	2. Date of De Month Januar	Day		of Death A M		
Funeral	3080 Tobacco  5. Social Security Number 6.	Sex 7. Age (	In yrs. last birthday)	Chesapea		h	Calve	rt	or Foreign		
Learl show cuilled at cotor	Usual Residence of Decedent 10a. State 10b. County	71 02	Oc. City, Town or Lo. Chesapeak	cation ce Beach		June 1.	y, Year) 1926				
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Event are must be muitibed.  To Be Completed by Funeral Director		12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	1944 1951 16a. Deced	10f. Zip Code 20732  Vas Decedent of Hir Yes, specify Cubar  □ Yes 2 ☒ No  lent's Usual Occupa kind of work done di 20 NOT use retired)	Specify:  ution  uring most of wor		Specif	ce - American Indian, ck, White, etc.  White usiness/Industry			
buld be filed withing Mental Hygiene.  arked other than atic event, the Matic event.	17. Father's Name (First, Middle, Las.	,	l	nance Sur			School , Maiden Surnan	Board			
Department of Health and Mentilling Department of Health and Mentilling Department of Health and Mentilling or other traumatic e once.	19a. Informant's Name/Relationship  Deborah M. Walk  20a. Method of Disposition  1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	n, State, Zip Code)  , MD 20732  - City or Town, State as, Virginia dome sas, VA 20110									
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his certificate has been s I director, page 2 should To Be Completed	25. Was case referred to medical					1 □ Yes	rmed? c	Nere autopsy findings orior to completion of c death? I □Yes 2 □ No	available ause of		
- g	examiner?    1   Yes   2   No										
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within 24 hou To the Fune completely fi	29b. Signature and title of oscillier	and manner stated		29c. License				(Month, Pay, Year)	,		
State Registrar	30. Name and address of prison who 31. Date filed (Month, Day, Wear)  JAN 2 8 2009	32. Registrar's	100 HO	spitelR.	d Sux	310 1	Ponce F	rederile,	20 Z		

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П	Physic	ian	1. Decedent's Name (First, Middle	,							Date of Dea     Month	ath Da	y Yea	3. Time of I	Death
	/Medi		Ernest McClai				1				January		2009		M
	Examir	ner	4a. Facility Name (If not institution,	,					Location of	of Death			. County of D		
	Funeral		3304 Clavier P. 5. Social Security Number		ie (In vre	last birthday)	If Under	nton	If Under:	24 Hrs	9. Date of Divi			George's	
	Funeral Director		424-54-1878	1X M 2□F	ic (iii yis.	69 Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da 4/12/1	n y, Year)	9.1	Birthplace (State or Country)	r Foreign
	pi .		Usual Residence of Decedent								4/12/1	939		AL	
	arylar show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside City	y Limits
	8a-f	Director		George's	C1	Linton								1X∑Yes	2 🗌 No
	with t	늅	10e. Street and Number				10f. Zip					10g. Cit	izen of What	Country?	
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2	be filed within 72 hours after death with the Maryland that Hyglene.  Id other than "natural", or items 23a or 28a-f show event, I'm Mcdical Evaniant, untituding the incitified at	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	ient's Usual	l Occupa	tion	m 6 sam what		16b. K	ind of Busines	ss/Industry	
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2	filed w Hygie tther t		12 17. Father's Name (First, Middle, L.	201)		Super	visor						. Gove	rnment	
au	e d al	Be C	Ernest McClair	,							(First, Middle,		Surname)		
<u> </u>	d 2 should be f Ith and Mental I 77 is marked of traumatic eve	ှင	19a. Informant's Name/Relationshi			10h Mailin	a Address	(Street a			Tellis				
S	12 tha		Ernest McClain,								Route Numbe				
ē.	of H		20a. Method of Disposition		20b. F	Place of Dispos cemetery, crem	sition (Name	e of	oren.					oz / 3 or Town, State	
Ĕ	permit. Pages Department of Important: If its any Injury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		I _	surrect		iei piace		an 3	0,2009	- C1 -	inton	MD	
saltimore, Maryland 21215-0036	eparti eparti ny Inj	1 7	21. Signatule of Funeral Service E	censee.	2	/7 22	. Name and	Address	of Facility	Str	ickland	Fur	neral 9	Services	
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É	Physician /Medical Examiner	Examiner	23a. Part F Enter the disease, or conshock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a Due to (or a) Due to	a consequ	uence of):		Tees	, such as t	Sardiac o	respiratory arr	est,		Approximate Interval Betwe Onset and De	eath
0,00,	ite be exec lysician and ne burial-tra	dical Exa	resulting in death) Last	c. Due to (or as a	consequ	uence of):	n Di	us. Zecos	e S	tuez	6				
Attending Physician The low comings that the double configure to	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of Live birth 4 Pregnant at 9 Unknown	of pregna 2 🏻 Fetal	ncy	Ectopic pre Other (spec	gnancy				2	3d. Date of de Month	elivery Day Yea	ar
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	State		Violet Habwe, 3 31. Date filed (Month, Day, Year)	700A St. Ba 32. Registrar	rnab	as Rd.,	Suit	land	i, MD	207	46				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A M Dorothy Muhs 27 2009 2:25 May January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Northampton Manor Frederick Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex Months Days Hours Min. 1 □ M 2 🔯 F New York Director 107-12-0176 93 May 15, 1915 Usual Residence of Decedent within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evanther must be notified at Director 1 □Yes 2 □ No Maryland| Frederick Frederick 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 200 E. Sixteenth Street 21702 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☒ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify White à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Douglas White Blanche Forrest 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6528 Nightingale Court New Market, Maryland 21774 Darlene Muhs / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 27, 2009 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) physician a the burial-t Physician/Medical the attending physical the state of the stat Box IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a o. ☐Yes 2☐No 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 s autopsy performed? page ( this certificate Vital 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical noletely and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

(2)

State 31. Date filed (Month, Per Year)
Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parked

D26499

1-28-09

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25 E11a mnuaru /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** May 13, Months Days Hours 1 M 2X F Maryland 213-24-8149 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 1 x Yes 2 □ No Maryland Frederick Thurmont Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21788 USA 23 N. Carroll Street Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Claire Frock 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Ella Jane Hahn Morris Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Elm Street, Thurmont, Maryland 21788 Jo Ellen Miller - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Removal from State 1-29-2009 Blue Ridge Cemetery Thurmont, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee Camelle 1621 Opossumtown Pike, Frederick, Maryland Approximate Interval Between Onset and Death art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Heavt tailure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COVONUVY Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trai and Due to (or as a consequence of) attending physician Box 68760, Physician/Medical use as IE FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Ectopic pregnancy Month Day in the past 12 mont Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, nronic Kidney Disease 2 No 3 Probably 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Obstructive Pulmonary 24a. Was an autopsy performed has 2 PN0 1 Yes 2 - No 1 Yes certificate of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) completely filled in by the funeral director, Be examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 3 🗆 DOA 2 ER/Outpatient မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Division or Attending 1 Natural Injury 1 Yes 2 No after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 4 Thomicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier KES-000 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 600 North Wolfe St, Baltimore, MD, 21287 Fontaine Natasha 32. Registre 's Signature 31. Date filed (Month, State 29 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Robert Donnell McKeown, Sr. 8:40 PM Jan. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil E1kton 725 Locust Point Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1)X M 2 □ F 215-22-4528 84 Director 3, 1924 Maryland Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐Yes 2 X No notified Director Cecil E1kton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21921 IISA 725 Locust Point Rd. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 9 1 ☐ Yes 2🛣 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Trucking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F George Boulden McKeown Sara Brown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Lincoln Ave., Elkton, MD 21921 Joan P. McKeown/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1-30-2009 1 ☐ Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 21. Signature of Funeral Service Lightee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. S. Queen St., Rising Sun, MD 21911 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Jach line. Approximate Interval Between Onset and Death Immediate Caus Final disease or con inton disease or con incresulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autops, performed: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ပို 27. Manner of D-ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 Hospital

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be

21215-0036

Baltimore, Maryland

**Physician** /Medical Examiner or Attending Physician; The law requires that the death certificate be executed Certification: within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation in a second control of the cause (s) and manner as stated. 29a. Certifier Medical Mèdical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type enmy 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

			For State Registrar	State of M	aryland / De	epartme C <i>ertifica</i>				-	giene Reg. No	2009	04229
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1	14		30. Name and address of person who c	ompleted cause of	death (Item 23a) (T	ype, Print)					Janua	ury 27,	2007
Ú	+/P		Yvette Warren, M.	). 1564 <sub>C</sub>	possumtov	vn Pik	e Fre	deric	k, MD	21702	,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene phys, DOR, 1- For Amend #2 per Registrar 1/30/09, LDB Reg. No. 2 1 1 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01-24-2009 **Physician** 2341 ason Marie 050 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. Talbot Hospita Memorial Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🛣 F 65 1709 31-50-Feb. 26.1943 Marylano Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director STON Talbot death with the 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number leasant Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify δ Black 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Coultry Industr ine Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental Pages 1 and 2 should be Unknown 2 <u>In Known</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pleasant Alley Apt. 1 JR. Easton, MD. 2160/ Joseph Esper Lee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/28/09 Midshore Cremation Cambridge, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Henry Fureral Home, P. A. 510 Washington St. Cambri 21. Signature of Funeral Service Licensee MD. 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner Die to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed erborate and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical Dronc the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the 9□Unknown 9 ☐ Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed are se of death (Item 23a) (Type, Print) gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Jay Year eor 2009 5: 55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Bay Center Dorchester Mallard Nursing ambridge If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug. 23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 220-58-5185 **Director** Maryl Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Funeral Director 1 Yes 2 No Dorchester ambridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 503 Street 23a 2/61 or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No ģ 1 ☐ Yes 2 🕱 No Specify: 3 ☐ Widowed 4 🔏 Divorced Biack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) Mental Hygiene. College (1-4or 5+) Technician 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and Menta Isiah or other traumatic ပ Rouzer SiR. Lorraine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other trau Cambridge, MD, 21613 Apt. 207 Rouzer 518Glenburn orraine 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Mambridg 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P. A. HENRY Funeral Hom. Cambridge 23a. Part 1. Inter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such s cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner s quantitative for the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed iding physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

Box 68760. Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

(Check only

29b. Signature and title of certifier

MATTBUBA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Territory Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Zona /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** Dorchester ambrida MT Dorchest Gene If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 86 Marylano Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a. State if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wester Evant was must be notified at 1 PYes 2 No Funeral Director 6 rida 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 61 U Ve, lood 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Proce cessina -00d Helper 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ၀ 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cambridge naton St. MD.21613 Moloc Sh. <u>Vnthia</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or ot once. 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Rock Cemetery 4 Donation 5 Dother (Specify) ambridge, 22. Name and Address of Prolity
HENRY FUNERAL HOME, P. A.
SIC Washington St. Cambri 21. Signature of Funeral Service Licensee MD.21613 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final therese Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ∐Yes 2 □ No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) \( 5 \) \( \text{Residence} \) \( 6 \) \( \text{Other (Specify)} \) 1 Yes 2 XNo 1 Propatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Régistrar's Signature State JAN29

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		,		tificate of		Re	g. N2 0 0 9	04233
r	Physicia	an	1. Decedent's Name (First, Middle, La	,					Date of Death     Month	Day Year	3. Time of Death
	/Medic		GILBERT THEODO  4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of Death	JANUARY	31 2009 4c. County of Dea	12:15 P <sup>M</sup>
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ary	z should be and Menta is marked aumatic ev	Ĕ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)
2	rt 27 ja		RUTH I. MYERS/SPO	DUSE				FERRY ROA		SEURG, MD	21782
ore	iges 1 and of the state of or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 [		20b. Pla	ace of Dispo emetery, crer	sition (Name of matory or other pla			20c. Location - City or	_
Baltimor	permit. Pages Department of Important: If Its any injury or o		4 □ Donation 5 □ Other (Special 21. Sign ture of Funer I Service Like		SAN	PLES 1	ANOR CEN	E. 2/05	/2009 S	SYARPSBURG ER FUNERAI	, MARYLAND
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o .	ricate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	a consequ	ence of):					
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3	To the Hospital or Al within 24 hours after of the Funeral Direc completely filled in by	Medical		miner: On the basis of and manner sta	examinati						
1	withi comp	Ž	29b. Signature and title of certifier	20 /		1 1 2	29c. Licens		29	Od. Date signed (Mon.	
6	XF		20 Name and addition of the	Mulant	-	MO		41667		L , L ,	0 /
12	3+1		30. Name and address of person who	Cornacle	eath (Item	,	Medica	1 Can	200 61	Leeriku	an MO.
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	r's Signat	ure					,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 0 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb 2. 2009 **Physician** 7:55pm <sup>™</sup> Mattingly Wanda /Medical 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Allegany Cumberland 720 Glenmore Street Birthplace (State or Foreign Country)
 MD Date of Birth (Month, Day, Yo Apr 29, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Year Months Days 215-26-9939 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland 10a State ral", or items 23a or 28a-f show Examiner must be notified at Cumberland 1 □¥es 2 □ No MD Allegany Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21502 USA 720 Glenmore Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2 □No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□Yes 2□N Baltimore, Maryland 21215-0036 Specify þ white 3 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leona Elizabeth Seymore True James D. True မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is any Injury or other trau M. Richard Mattingly 720 Glenmore Street Cumberland husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 2/6/2009 MD Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility rai Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the insease, or combications that caused the death. shock, or heart ailure. List only one cause of learn line. Immediate Cause or inal disease for condition resulting in death) Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** /Medical Due to (or as a ons uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOU MENDURIAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

Dr

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 2009 1:58 P M JOHNETTE. NEWMAN CLARCY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2√□ F 66 213-42-5337 Director VIRGINIA MAY 13 1942 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10d. Inside City Limits 10a. State 10h. County 10c City Town or Location show ir than "natural", or items 23a or 28a-f shov 1 X Yes 2 □ No Director CAPITOL HEIGHTS MD PRINCE GEORGE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20743 1162 BOOKER DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, et 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. <u>Ş</u> 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT SECRETARY 12TH is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LILLIE MAE WOODRUFF TOLLER OSCAR ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6939 FOREST TERRACE LANDOVER, MARYLAND 20785 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. MARESHA NEWMAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/2009 HARMONY CEMETERY LANDOVER, MARYLAND 22. Name and Address of Facility 21. Service License J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part I/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FATAL CARDIAC ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions Due to (or as a consequence of) Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Year Month Day 5 Other (specify) P.O. 1 the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ PARKINSON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HX OF CVA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2√ No 1 ☐ Yes PULMONARY EMBOLISM or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🕅 Natural 5 Pending investigation death. ieral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier 1 detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MD DOOG 3558 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 MERCANTILE LANE UPPER MARLBORO, MARYLAND 20774 MELISANDE SMITH M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State JAN 2 A 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** M1440 Ma a 80 Jan 000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 511 MOSP DY Mon C1059 Vei 20mery If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 82 Yrs April 0, 1926 5. Social Security Numbe 579-34-2218 9. Birthplace (State or Fgreign 7. Age **Funeral** Days Hours 1 □ M 2 X F Months Massachusetts Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evarsises must be notified at Silver Spring Maryland Montgomery 1 □Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3128 Gracefield Road, HS309 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Analvst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace M. O'Connor Joseph E. Kline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia C. Mathews -daughter 13100 Cox Court Ellicott City, Maryland 21042 Baltimore. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 1/28/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses BoNald V∵®BoFgWardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Su disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WID Examiner be executed Due to (or as a consequence of): burial Records, P.O. Box 68760 physician Physician/Medical requires that the death certificate the. attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnani in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) the detached a∏lJnknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been ( 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physiclan: The within 24 hours after death.

To the Funeral Director: After this certificate he completely filled in by the funeral director, page 1 ☐ Yes 2 🗷 No Division of Vital 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred fell arthing 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending Injury MOCEC 1 ☐ Yes 2 20 No 0 } bel 2 Accident investigation POOS 25 2009 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, ' P. City or Town, State) 3 / 6 3 Grace records 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Home Norgina 501/00 mD 20904 SILVET Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

10

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of

mo arkhur 5 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

3/10

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene N4238 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** Pankey Velma Vernell 27, 11:45 a<sup>™</sup> Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1207 Addison Rd. #134 Capitol Heights Birthplace (State or Foreign Country)
 VA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2 🕅 F 81 Months Days Hours 227-36-9348 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Exercipes must be notified at ence. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Capitol Heights PG 1 Yes 2 No MD Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 USA 1207 Addison Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson Pankey William Alfred ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Smoot/Daughter 70 Harbour Heights Dr., Annapolis,MD 21401 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other r Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Heritage Cemetery 02-07-2009 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21. Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BREASI **Physician** CANCER 8 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transi Examil Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by CONGESTIVE HEART 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 No 1 ☐ Yes 2 🗷 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 747604 Marrew 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3048 MITCHELLVILLE ROAD, BUNE, MD 20+16 SCBHAN MATHEW 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 19:15 PM HARLEN 2009 JANUARY /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BATVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia Age (In yrs. last birthday) Date of Birth (Month, Day, ) une 11, **Funeral** Days Year, 1**X** M 2□ F 228-52-5188 68 1940 Director June Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If Item 23a or 28a-f show any Injury or other traumatic event, The Medical Exemple; must be notified at 10a State Director 1 ☐ Yes 2 No Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4057 Saint Augustine Lane 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 72 hours after 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Har-Lane Express es 1 and 2 should be filed wi of Health and Mental Hygier I Item 27 is marked other th Office Manager 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roxie R. Mahalev Amos L. Pope ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4057 St. Augustine La., Baltimore, MD 21222 Joann Phillips Pope (Wife) Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pope Family Cemetery 1/22/2009 Abingdon, VA 22. Name and Address of Facility
Weaver Funeral Home 21. Sign: ture of F, neral Service Lice ee lenns 630 Locust St., Bristol, TN 37620 lun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY **Physician** FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a consequence off law requires that the death certificate be executed Examir and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. I the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s performed?

1 Yes 2 No certificate Division of Vital 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Hospital or Attending P 24 hours after death. Funeral Director: After t 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the I within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

JANUARY 17, 2009

			For State Registrar			d / Depa		t of H	ealth a		lental Hyg		009	0424	0
	Physicia	an	Decedent's Name (First, Middle     Jack Andrew Pin								2. Date of Dea Month January		200g	3. Time of Death <b>6:25 p.</b>	
A.	/Medic	al	4a. Facility Name (If not institution,		ber)		4b. City.	Town, or	Location o		January		County of De		141
	Examin	er	St. Catherine	•		5		nitsl					rederi		
	Funeral Director		5. Social Security Number 117-10-5819	6. Sex 7 1 ★ M 2 F	. Age (In yrs. <b>95</b>	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jan 27,		(	irthplace (State or Fore Country) <b>braska</b>	ign
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Mont	gomery	10c. Cit	y, Town or Lo Bethes								10d. Inside City Lim	
	death with the Maryland ms 23e or 28e-f show rimat be notified at	i Direc	10e. Street and Number 7319 Bradley	Boulevard			10f. Zip	Code 20817	7			0g. Citiz	en of What (	Country?	
036	be filed within 72 hours after death with the Marylan Hygiene.  d other than "natural", or Items 23s or 28s-f show other than "natural", or Items 23s or 28s-f show event, Its Medical Examinating the ordified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marri  3 Widowed 4 Divorced	12. Was Deced Armed Ford ed 1 Gyes 2 If Yes, Give Year or Dat	es? ! [] No		Was Deced If Yes, spec			gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		4. Race - An Black, Wh Specify:	nerican Indian, nite, etc. white	
Maryland 21215-0036	within 72 ho ene. then "natur	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-	4or 5+)	16a. Deced (Give life.				t of worki	ng		d of Busines	·	
121	iled w Hygier ther th		17. Father's Name (First, Middle, I	4		Finar	ncial	ana.		ar's Name	(First, Middle,		D.I.C.		
/lanc		To Be	Paul Pinion	Last)							derson	111210011			
	s 1 and 2 should t Health and Mer ttem 27 is marks other traumatic		19a. Informant's Name/Relations? Richard L. Pinio				-				mac, Ma	-		. <i>Zip Code)</i> 1 <b>854</b>	
Baltimore,	m O I		20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5 Other (S)			Place of Dispo cemetery, crer auffer					-2009			or Town, State  Maryland	
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Services	Eicensee Mulle	1		2. Name an <b>621 0</b> 1				auffer ke, Fre				702
760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending physician and more prompted programmers of the funeral director. After this certificate has been signed by the attending physician and programmers of the funeral director, page 2 should be detached for use as the burial-transit.	dicai Examiner	shock, or heart failure. List the third that the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	r as a conseq	uence of):	The	9 27-10	The	au x	nafi 1920-	el		Interval Between Onset and Death 2 Weeks	K
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2∏Feta ntattime of c	Ideath 3	⊒Ectopic pr □ Other (sp					2	3d. Date of o	lelivery Day Year	
rds, P.	quires that I n signed by uld be deta	ed by Ph	Part II. Other significant condition	ons contributing to de	ath but not res	culting in the u	inderlying c	ause give	en in Part,I.	a	23e. Did to		-	to the cause of death?	
Vital Records,	The law re cate hes bee page 2 sho	Completed by	Per phuro	l Vox	cal	ar !	Dis	-e a	se.		24a. Was a autop perfor 1 Yes	sy	prior to death	autopsy findings availa completion of cause ? es 2 \( \text{No} \)	ble of
<u>ita</u>	iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	20		(Check only or				
Division of	nding Phys tth. :: After this e funeral di	ation: To	1 Yes 2 No  27. Manner of Death N Natural 5 Pendin 2 Accident investig	28a. Date o		28b. Time o Injury		8c. Injury Work	4 JE NU		me 5 Resid			pecify)	
Divis	al or Atters after des la Director de in by the	Certification;	3 Suicide 6 Could r 4 Homicide determ	inad 286. Place	of Injury - At h g, etc. (Speci	ome, farm, sti	reet, factory	r, office			28f. Location (S City or Tow	treet and n, State)	Number or	Rural Route Number,	
	he Hospit in 24 hour the Funera pletely fills	Medicai (	(Check only 2 Medical one)	g Physician: To the Examiner: On the ba and mann	sis of examina	wladge, deen ation and/or in	h occurred ivestigation	at the thr , in my or	na, date an pinion, dea	id clane; i ith occurr	ed at the time, o	ate and	place, and d	ue to the cause(s)	
	To the vithin 2 To the complet	Σ	29b. Signature and title of certified	J. Ch	uf	el-f	31 70	E. License	DO number	140	0440			nth, Day, Year)	
(	95)		Name and address of person	Rempe	C-R	RTI	Print)	).c	EL	1-1 vii	23 W	est us	ina, lus	15 Just C	
2	Sta Registr		31. Date filed (Month, Day, Year)	2000	gistrar's Signa		orke				,	U			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 14, **Physician** 2009 8:30 PM Patterson January Barbara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Perryville 11 Chesapeake Landing Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Abril 26, 1929 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F 577-34-1531 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Perryville Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21903 11 Chesapeake Landing Drive Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify White þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home maker d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine V. Dixon John J. Snider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Jill Mc Kinney/Daughter Chesapeake Landing Drive, Perryville, MD 21903 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans' Cemetery: 1/26/2009 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3035 01d Washington Road Signature of Funeral Service L Huntt Funeral Home Waldorf, Maryland, 20601 M012.84 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cumu /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examine or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the ! IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 2 N 1 □Yes 25. Was case referre o medical 26. Place of Death (Check only out) funeral director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Registrar
DHMH 17 Rev 1/2001

Unin

Registrar's Signature

news

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonth, Day, Yo

31. Date filed (

JAN 29 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JANUARY 26 26 2009 8:12 PM JAMES LYNN POTTER 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Months Days Hours 1 🔀 M 2 🗆 F West Virginia 73 March 23,1935 232-52-7866 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h County 1 ☐Yes 2 N No Maryland Maryland Frederick New Market 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11835 Vineyard Path 21774 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 123 Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 T Married 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specity only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Communications Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Sparks

Manasseh J. Potter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Jean Potter / Wife 11835 Vineyard Path New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition

5 ☐ Other (Specify) Stauffer Crematory 29, 2009 Frederick, Maryland 4 Donation 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Se

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 Approximate Interval Between Onset and Death

January

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

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Due to (or as a consequence of)

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Due to (or as a consequence of):

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IF FEMALE:

1 - For State Registrar

10a State

**Funeral Director** 

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Completed

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exp. in a finish to profiled at

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Department of Health Important; If Item 27 any Injury or other trong once.

**Physician** /Medical

Examiner

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after death.

Director: Af d in by the fur

To the Hosl within 24 ho To the Fund completely is

physician

Hospital or Attending Physiclan; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? 1 🗆 Yes 2 🗆 No

Year

25. Was case referred to medical examiner?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

autopsy performed?

1 Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation

Date of Injury (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28d. Describe how injury occurred 1 ☐ Yes

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 Homicide

12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year) 09

CARRI 31. Date filed (Month

120 32. Registrar's Signature april

-rederive

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 04243 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:55 P M 2009 27 Elisabeth Mary Parncutt January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Casey House Rockville 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ireland 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Hours Months Davs 1 □ M 2 1 F 1934 May 28. 104-34-7704 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐ Yes 2X No Germantown Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20874 Ireland 3 Cross Ridge Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 X Married 1 □Yes 2 XNo Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Josephine Barratt Michael Patrick Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Cross Ridge Court Germantown, MD 20874 Geoffrey Parncutt/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) W. Arundel Crematory 01/30/09 Odenton, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box
Beverly L. Heckrotte, P.A. Clarksville. 21. Signature of Funeral Service Licer P.O. Box 784 MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Cancer of Unknown Primary disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be refitted at once.

Baltimore, Maryland 21215-0036

/Medical

Director MD

Funeral

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Completed

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attending physician and for use as the burial-tran After this certificate has been signed by the funeral director, page 2 should be detached n 24 hours after death.

e Funeral Director: Af

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical Be Completed by Medical Certification: To

IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □ Yes 2X No 9 □ Unknown	nt	3c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Fetal tat time of d	Ideath 3□	Ectopic Other (s			_		3d. Date of delivery Month Da	y Year
Part II. Other significant co	onditions cor	ntributing to death	n but not resu	ulting in the und	erlying	cause	e given in Part I.		23e. Did tobacco us	se contribute to the c  No 3□ Probabl	
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25. Was case referred to m	edical	" "					26. Place of Dea	th (	Check only one)	·	
examiner? 1 ☐ Yes 2 █️No	F	lospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatient	3 🗆 🗈	OA	Other: 4 I Nursing H	ome	5 ☐ Residence 6	Other (Specify)	hospice
	Pending nvestigation	28a. Date of I (Month,	njury Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes 2 □ No	280	d. Describe how injury	occurred	
	Could not be determined	28e. Place of building,	Injury - At ho etc. (Specif	ome, farm, stree	t, facto	ry, off	ïce	28f	Location (Street and City or Town, State)		oute Number,
			s of examina				he time, date and place my opinion, death occu				

29c. License number

DEB 63748

To the Hosp within 24 hor To the Fune completely fi (D)2

JOCEL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

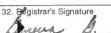
Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

29d. Date signed (Month, Day, Year)

January 29, 2009

State Registrar 31. Date filed (Month, Day, Year) JAN 30

29b. Signature and title of certifier



KOUATCHOU, M)

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Funeral		i. Social Security Number 6.	Sex 7. Ag	e (In yrs. last b	irthday) I	Under 1 Year	If Under 24		th(MM/DD/YYYY)	J. Birthplace (S oreign	State or
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	(Type, Print ) / Mo	+ b a re V	19b. Mailing A	dress (Street	t and Numbe	r or Rural Route Nu	mber, City or Town,	State, Zip Con	de)
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other trainmain event, the Medical Examiner must be notified at once.	-	Tracy W. Quin	nichett	cher /	8229	Lvndhi	urst	St. Lau	rel.MD	20724	
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Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is injury or other trainmat	k	Iluras TV	MANO	alu	246	N. W	ashin	gton St	,Rockvil	lle,MD	
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Division  Hospital or Attent 24 hours after death Funeral Director: tely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the hest of	my knowledge	death occurre	d at the time, d	ate and plac	e, and due to the ca	use(s) and manner	as stated.	
Division of Vital Records, P.O. Box 68760, within 24 horspital or Attending Physician: The law requires that the death certificate be within 24 hors after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	lica	(Check only one) 2 Medical Exam	iner: On the basis of ex	amination and	or investigatio	n, în my opinior	n, death occu	urred at the time, da	te and place, and di	ue to the cause	e(s)
To To con	Medical	29b. Signature and title of certifier	and manner states	u		29c. Licens			29d. Date signe		
4		James 17 Van Ale	Il MA			O.C.	.M.E.		January 22	, 2009	
	1 3	30. Name and address of person w	no completed cause of	f death (Item 2	3a)						
		Pamela E. Southall, MI	) Assistant Me	dical Exam	iner 111	Penn Stree	et, Baltimo	ore, MD 21201			
S	tate	31. Date filed (Month, Day, Year)		1 01							
Regis		31. Date filed (Month, Day, Year)	109 Seneura	J B.	park						
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i	Physici /Medic		Decedent's Name (First, Middle     J. D. Rayno								2. Date of Deat Month January	Day	Year 2009	3. Time of Death 7:00 A. M	
>	Examir		4a. Facility Name (If not institution 400 Birchleaf	, give street and nu	mber)		4b. City, T		Location o		s	4c. Col	onty of Death		
Ī	Funeral Director		5. Social Security Number 246–26–0124	6. Sex 1 ☑ M 2 ☐ F	7. Age 84	(In yrs. last birthday, Yrs.	If Under 1		If Under Hours		8. Date of Birth (Month Day 07/13/1		9 Birth	place (State or Foreign ntry) Oaks, N.C.	
9036	should be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or iteme 23e or 28e-I ahow imatic event, if a Medical Examination must be notified at	d by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Md.  10e. Street and Number  400 Birchlea  11. Marital Status  1 Never Married 2 Marr  32 Widowed 4 Divorced	12. Was Dec Armed Fo	edent Evorces?	ver in U.S. 13.	ol Hei	207 ent of His by Cubar	43 spanic Ori n, Mexicar		ecify Yes or No- Rican, etc.)	14.1	of What Cou  U.  Race - Amen Black, White, ecity: Af	S.A.	
Maryland 21215-0036	e filed within 72 h ii Hygiene. other then "netu vent, the Medice	Be Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 9Eh 17. Father's Name (First, Middle,	College (	1-4or 5+	(Give	dent's Usual kind of work DO NOT use ler Op	done d retired,	tor		ing Na	u.S	. Gove	ch Lab	
	d 2 uth ar that traut	To E	Daty Rayno: 19a. Informant's Name/Relations: Eunice Wise/Dauce	nip (Type, Print)		Armethere Will  19b. Mailing Address (Street and Number or Rural Route Numb  16506 Village Drive West, Upper  20b. Place of Disposition (Name of Date							ber, City or Town, State, Zip Code)		
Baltimore,	it. Page intment o intant: If injury or		20a. Method of Disposition  1 2 Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)  21. Signature of Funeral Service	pecify)	State	20b. Place of Disposemetery, cre Harmony	osition (Name matory or oth Mem。 P	e of ner place ark	20c. Location - City or Town, State  Landover, Maryland  Inc.						
g	Deperment impo		23a. Part1. Enter the disease, or	My Complications that of	aused t	he death. Do not en	1925 Bi	urro	ughs	Ave		ashin	gton,D	.C.20019 Approximate Interval Between	
8760,	be a secuted by secuted by secution of the sec	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Bequentially list conditions, of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Diabetes Mellitus, Type II  Due to (or as a consequence of):  Anemia												Onset and Death	
.O. Box 6	at the death certific by the attending p tached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 nant at ti	Fetal death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>					23d.	Date of deliv Month	ery Day Year	
<u> </u>	The law requires that the ete has been signed by the page 2 should be detache		Part II. Other significant condition	ons contributing to d	eath but	not resulting in the u	ınderlying ca	use give	en in Part I			acco use o		he cause of death?	
al Reco	ysician: The law re is certificete has ber director, page 2 sho	Completed									24a. Was a autops perform	У	4b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of	
Division of Vital Records,	Attanding Ph or death. Octor: After thi by the funeral	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin investig  2 Accident  3 Suicide 6 Could determ	g 28a. Date (Mon	of Injur		of 28	lc, Injury Work	er: 4 □ Nu	ursing Ho	th (Check only on ome 5 Reside 28d. Describe ho 28f. Location (St City or Town	once 6 Downinjury oc			
<b>_</b>	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medical Ce	29a. Certifier 12 Certifyir (Check only one) 2 Medical	g Physician: To the Examiner: On the b and man	asis of e	my knowledge, dea examination and/or in ed.	th occurred anvestigation,	it the tim	e, date an pinion, dea	nd place, ath occurr	and due to the cared at the time, d	ause(s) and ate and pla	f manner as s ce, and due t	stated. o the cause(s)	
	4+1	M	29b. Signature and title of certifie		50 of d	Sall	Г	License 0584	number 11		2	9d. Date si	gnéd (Month,	Day/Year)	
_		10	30. Name and address of person Kimberly Boll  31. Date filed (Month, Day, Year)	ing,M.D.	4000	Mitchel		Road	4 2	04 <b>,</b> B	owie,Mar	yland	2071	6	
	Sta Regista		JAN 29 2009	Denous	J.	's Signature									

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 27, 2009 2:35P. M Frances Rubin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forest Hill Harford Rock Spring Village 8. Date of Birth Dec. 26, 1912 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign New York **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 083-01-4663 96 Director Usual Residence of Decedent death with the Maryland 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Colgate Drive 21050 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Typist Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Gartenlaub (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita E. Haven -daughter 1604 Mortho Court, Unit 101 Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Lebanon Cemetery 1/29/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) y eans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, the line Limited Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) signed by the a d be detached for Division of Vital Records, P.O. 1 ☐ Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been si page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🖾 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending I thin 24 hours after death. the Funeral Director: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Ce H39022 January 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1308 Business Center Way Edgewood, Maryland 21040 LoPresti, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04247 State of Maryland / Department of Health and Mental Hygiene [] [] 9 State
Registrar AMEND#80ex FH1-29-09, EMW, McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year AMES 15338M RICE 09 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE SOUTHERN MARYLAND HOSPITAL SUITLAND MARYLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10 23 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 🖾 M 2 🗆 F 64 SC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 No Prince Georges Suitland MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20746 USA 5175 Clacton Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1965 – 1 Tyes 2 □ No If Yes, Give 1971 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Federal Gov. Postal worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sadie Gambrell Neotha Rice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10107 Baltimore Ave. #4303 College Park MD 20740 Kimberly Rice/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran's 2 Cheltenham, MD 2/5/09 4 Donation 5 Dother (Specify) 21. Signature of Emeral Service Licensee 4217 9th StNW Marshall's Funeral Home Washington DC 20011 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea or condition resulting in death) HEPATIC ENCEPHELOPATHY min-his Due to (or as a consequence of): months ALCOHOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed 2 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner?

Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 🗌 Homicide

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiclan:

Examiner burial-transi After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical Completed Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event instituted at

**Physician** /Medical

Examiner

29a. Certifier

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) D0067761 01-23-09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5100 Auth way, Suitland, Maryland 20746 Shital Desai MO. 31. Date filed (Month, Day, Year)

State Registrar

10

Medical

esa mo



			For	State of Maryland / Dep	partment of Health and	Mental Hygie	ne2009 04248	
			State Registrar		ertificate of Death	Reg.	No.  3. Time of Death	
	Physicia	an	Decedent's Name (First, Middle, La				Day Year	
	/Medic	al	Warren Will: 4a. Facility Name (If not institution, giv	liam Rosier, Sr.	4b. City, Town, or Location of De-		26, 2009 4:20 A M	
	Examin	er		2700 Rambler Place	Hyattsville		Prince George's	
-	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs. last birthda			Birthplace (State or Foreign	
ш	Director		579-46-0709	XM 2□ F 70 Yrs.	Months Days Hours Wil	July 15,		
-	P .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examirser must be retified at or other traumatic event, the Medical Examirser must be retified at	ō	District of (				tx∑Yes 2 ☐ No	
		rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?	
		iO E	1011 - 30th Str	eet. SE	20019	U	nited States	
		<b>Funeral Director</b>	11. Marital Status		3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.	
9			1 ☐ Never Married 2 【 Married	11 Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:	31.0 11.00.1, 0.0.1,	African	
003	ural",	d b	3 Widowed 4 Divorced	Year or Dates:	cedent's Usual Occupation	161	American  D. Kind of Business/Industry	
15	n 72 h "natu	olete	15. Decedent's E (Specify only highest gr	ade completed) (Gi	ve kind of work done during most of w b. DO NOT use retired)	vorking	Government	
21215-0036	12 should be filed within ? h and Mental Hygiene. 7 Is marked other than " traumatic event, If e Me.	Be Completed by	Elementary/Secondary (0-12)	1 year (1-4or 5+) Compu	iter Technician Si	pervisor (	Dept. of Army)	
þ	al Hyg other		17. Father's Name (First, Middle, Last	)	18. Mother's N	ame (First, Middle, Mai	den Surname)	
Maryland	uld be Menta Irked Itlc ev	70 E	Charles William			othy Jones		
lar)	2 sho and l		19a. Informant's Name/Relationship	· · · · · · · · · · · · · · · · · · ·	ailing Address (Street and Number or			
	1 and 2 Health em 27 other tr		Vera J. Rosier -		- 30th Street,		c. Location - City or Town, State	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tronce.		20a. Method of Disposition 1	J Hemoval from State	sposition (Name of rematory or other place)  Memorial Cemt. J		•	
ij			4 □ Donation 5 □ Other (Special Service Light Light Service Light Light Light Service Light Light Light Service Light L	77	'			
Ba			4001 Benning Road, NE Washington, DC 20019					
	Physician /Medical Examiner		23a. Part 1. Neter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Advanced Dementia  Applications are described by the first of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest of the cause					
- North			Immediate C 45 (Final disease or condition resulting in death)	5 years				
			resulting in death)	Due to (or as a consequence of):				
			Sequentially list conditions,	b Due to (or as a consequence of):				
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Lind Underlying Cause (Disease or injury that initiated events					
ó		Exa	resulting in death) Last	Due to (or as a consequence of):				
1760,	ate be nysicia ne bu	ical	d					
89 )	ertifica ling ph e as ti	Med	IF FEMALE:					
Box	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant In the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy				23d. Date of delivery  Month Day Year	
0	he de	ysic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
σ.	ding Physician: The law requires that the death certificate be executed n.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burlat-transit	Completed by Ph	Part II. Other significant conditions	contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?	
Records,				2 No 3 Probably 4 Unknown				
00						24a. Was an	24b. Were autopsy findings available prior to completion of cause of	
R						– autopsy performe 1 □ Yes 2 🛣	d? death? ☐No 1 ☐Yes 2 ☐No	
Vital		BeC					ath (Check only one)	
of V	Physician: this certific		examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			Assisted Assisted Injury occurred Living	
u	nding P tth. :: After t e funera	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time Injur		28d. Describe how	injury occurred	
isio	death death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not	be 380 Place of Injury . At home form		28f. Location (Stree	et and Number or Rural Route Number,	
Division	after of Direct I Dir	Certification: To	4 Homicide determine	building, etc. (Specify)		City or Town, S		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	cal C	29a. Certifier 1 Certifying F	Physician: To the best of my knowledge, daminer: On the basis of examination and/o	eath occurred at the time, date and plor investigation, in my opinion, death o	ace, and due to the cau	se(s) and manner as stated. e and place, and due to the cause(s)	
	the H thin 24 the F mplete	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		I. Date signed (Month, Day, Year)	
	To To			- Nell rel	D22309		January 28, 2009	
9	M		V · M	o completed cause of death (Item 23a) (Tyl		J	andary 20, 200)	
0	-1			h, M.D. 8712 Maywoo		Spring, MD	20910	

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11.08 Evelyn Sartor Jankas 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Virginia 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Months Days Hours 1 □ M 2 🛛 F 71 1938 Jan 579-50-7615 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Prince Georges Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #204 7603 Mandan Road USA 20770 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ∐Yes 2X No Specify Specify: 3 ☐ Widowed 4 X Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Tech. Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bowles Earl Barnett Pansy 19a. Informant's Name/Relationship (Type. Print) 7603 Mandan Road #204 Greenbelt, MD 20770 Marcia Coleman/Daughter Greenbelt, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Riverdale Crematory 1/27/09 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 21. Signature of Euneral Service License 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, N.W., Washington, DC 20011 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final TENSION

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Funeral

Completed by

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and other traumatic event, the Medical Examination and once.

attending physician and for use as the burial-tran signed by the a d be detached for certificate has birector, page 2 sl After thi funeral within 24 hours after death

To the Funeral Director:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	resulting in death)  Due to (or as a consequence of):							
ical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Chyeric Revol Faculticial Revolution Revolut							
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				23d. Date <i>o</i> f delivery Month Day Year			
ed by PI						use contribute to the cause of death?		
Complet					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
ee ee	25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
	ILI les ALINO	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)				6 ☐ Other (Specify)		
	27. Manner of Death 12 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how inju	ury occurred		
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical certification. 10	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
A	29b. Signature and title of certifier			29c. License number	29d. Date signed (Month, Day, Year)			
	) (oClean			MD 30858	Jana	lary 18,200 g		
	30. Name and address of person who of	1/	Good Luck	L Road Lon.	han, MD.	20706		

State Registrar Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death

Physician /Medica Examine

1 - For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

> State Registrar

31. Date filed (Month, Day, Year)

JAN 29 2009

	State Registrar  Certificate of Death  Reg. No. 2009						50		
	Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of De	eath		
an al -	John Francis Stohlman				y 25, 20	09 11:37	рМ		
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	1	4c. County of	f Death			
	Charlotte Hall-Veteran's Hom		Charlotte		St. M				
	5. Social Security Number 6. Sex 7. Age (In 1 M 2 □ F 7. The second security Number 1 M M 2 □ F 7. The second sec	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.							
	Usual Residence of Decedent  10a. State 10b. County 10c	ation			10d. Inside City				
cto	Maryland St. Mary's	Mechanio	csville			1   Yes 2	- DANO		
Completed by Funeral Director	10e. Street and Number 42172 Patuxent Drive	10f. Zip Code 20659 10g. Citizen of What Country? USA			nat Country?				
	11. Marital Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 ▼ I Yes 2 □ No If Yes, Give Year or Dates: 1	l If	Tas Decedent of Hispanic Origin? (Si Yes, specify Cuban, Mexican, Puerto ☐ Yes 2☑ No Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc. White			
pleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give k	ent's Usual Occupation ind of work done during most of work O NOT use retired)	16b. Kind of Bus	iness/Industry				
Хош	1	Watch	n maker		Jewe	lry			
Be	17. Father's Name (First, Middle, Last)  Martin A. Stohlman		18. Mother's Nam Elizabeth		Maiden Surname	)			
ဥ	19a. Informant's Name/Relationship (Type. Print)	19h Mailing	Address (Street and Number or Ru		er City or Town S	tate Zin Code)			
	Joyce Elaine Stohlman/Wife		172 Patuxent Driv				59		
	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  31								
	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901								
	23a. Part1. Enter the disease, or complications that caused the					Approximate Interval Betwe			
Je.	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CEREBRAL VASCULAR DISEASE  Due to (or as a consequence of):								
	Sequentially list conditions,  If any leading to immediate  Due to (or as a consequence of):								
amin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events say library in death). Leading the conditions of the condition								
ical Ex	resulting in death) Last  Due to (or as a consequence of):  d.								
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					23d. Date of delivery Month Day Year			
/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to						ath?		
d be	ESSENTIAL HYPERTENSION 10 Yes 20 NO 30 F						known		
complete	RENAL ARTERY STENOSIS  24a. Was an autopsy performed? performed? 1 yes 2 1 yes								
3e (	25. Was case referred to medical examiner?  26. Place of Death (Check only one)								
길	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 6 Other (Spe								
Medical Certification:	27. Manner of Death 28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work? 2 Accident investigation  28b. Time of Injury M  28c. Injury at Work? 1 Yes 2 No								
	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or F City or Town, State)						er,		
dical (	29a. Certifier (Check only one)  1								
Me	29b. Signature and title of gertifier  Aleules; MD		29c. License number DE 7788	29d. Date signed (Month, Day, Year)			3		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA RAO KODALI 29449 CHARLOTTE HALL RO., CHARLOTTE HALL, MC								

DHMH 17 Rev 1/2001

pares

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Siddiqui Physician G 45 PM Sheerin Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country)
April 20,1925 Pakistan Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👽 F Months Days Hours 152-88-2114 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla InDepartment of Health and Mental Hyglene. InDepartment: If item 27 Is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, its Mulcal Examiner rust be notified at once. 1 □Yes 2 □ No Director Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10474 Graeloch Road 20723 Pakistan Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Asian Specify: Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>own home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mohammed Ali Siddiqui (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zəhid H. Siddiqui -son 10474 Graeloch Road Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD National Mem. Park 1/26/2009 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Bonala V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee, Monald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocordia inforction /Medical Due to (or as a consequence of): **Examiner** Cardiamyopith 15 Chamic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Curcles Voscolar Atherosclerotic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) I □Yes 2 ₽No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Phenmenia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Renal 1 MSUfficiency 1 ☐Yes 2 ☑No 1 □Yes 2 🗖 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 INO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To I Director: After this ed in by the funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) i 24 hours after d e Funeral Direct letely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0043662 Jan 25, 2009 7,000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAM JBOYCE Howard County hen Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04252 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200<sup>g</sup>ar 26°, Meriam Shapiro January 5:18 P M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, )
March 5, Birthplace (State or Foreign Country)
 DC 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex . 192<u>3</u> Min. 1 M 2 F Months Days Hours 579-20-7281 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Director MD Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6121 Montrose Road 20852 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2XNo If Yes, Give Year or Dates: Specify. White Specify: by 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Merchant Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry S. Gildenhorn Annie Geifman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Lazerow - Daughter 8602 Long Arce Court Bethesda MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Rem. Mem. 1/29/09 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Lic 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OBSTRUCTIV HKONIC disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PINO 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

ed by the a detached for signed t icate has been si

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Division of Vital Records,

**Funeral** 

Director

28a-f show

with

filed within 72 hours after

1 and 2 should be fi Health and Mental

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Experimer must be netified at

Department of Health a Important: If item 27 is any injury or other trau once.

**Physician** 

/Medical

Examiner

aftending physician and for use as the burial-transit Physician/Medical þ Completed certificate has funeral director, Be Certification: To After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral

6 Could not be determined 3 Suicide 4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

tile Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 018084 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 29 State Registrar

29a. Certifier

(Check only one

Medical

MONTROSE RD, RECKVILLE MDZO852 MD Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 04253 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0750 A M Charles Η. Smith 2009 /Medical Jan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Bethesda, MT Montgomery If Under 1 Year | If Under 24 Hrs. 5 Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 1 M M 2 □ F 90 Months Hours Min 7/25/1918 579-03-0505 Director Pamplin, VA Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exactiner must be notified at Director 1X Yes 2 □ No DC Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 47th Place, NE 1034 20019 items 23a United States r death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 194 dar or Date 9:45 1 ☐Yes 2 No Specify Specify: Black þ 3K Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Engineer DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Charles Smith Mattie Berryman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carla Johnson / Daughter 2321 East Gate Drive, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery : 1/28/2009 Washington, DC 4 Donation 5 Dother (Specify) 21. Signature Funeral Service Licensee Pope Funeral Home, 2617 Pennsylvania Avenue, SE Washington, DC Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Box 68760, Physician/Medical attending pt for use as ti IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 Other (specify) P.0. the 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown as been si 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page this certificate 2. No 1 ∐Yes 2 ∐No 1 ☐Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred or Attending 1 Natural 5 Pending within 24 hours after deau.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number - 19-09 Mnes D063999 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 18111 PRINCE PHILIP DR OZNEY 20832 MOTAMEDI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MICHAEL SINGLETON JAN. 2009 2319 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

JULY 20,1956WASHINGTON, DC 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days **X**□ M 2□ F Hours Min. 5 2 Yrs. 579-76**-**2403 Director JULY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural any Injury or other traumation." ST., 3358 AMES 20019 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐Yes 2X No ģ Specify: BLACK 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) 12 LABORER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) STANLEY SINGLETON DOROTHY STEVENSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE CUTCHEMBER/DAUGHTER 3358 AMES ST., NE WASH., D.C. 20019 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State CHESAPEAKE CREM. 5 ☐ Other (Specify) 2/04/09 |BELTSVILLE, MD 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature of Funeral Service Licensee or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, st only one cause on each line. D C 20002 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. ist only one cause on each line Immediate Cause (Final disease or condition resulting in death) Atheroscleratic Coronary Artery **Physician** /Medical Due to (or as a consequence of) Examiner stric tron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine APPROVED BY MEDICAL EXAMINE Due to (or as a consequence of) CERTIFIC Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical examiner?

Yes 2 □ No 26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deat To the Funeral Director:

State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES LIGHTFOOT 7600 CARROLL AVE., TAKOMA PARK, MD.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

1/27/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Covel Suthard, Sr. 26, 2009 January  $11:20 \, A^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mount Airy Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F Months Days Hours 579-46-6357 Director June 17, 1936 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, it e Medical Exp. ut at must be realified Director 1 ☐Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 7024 Edgemont Road 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1959- Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: White þ 1965 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elisha E. Suthard Estelle Heflin ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trains Betty L. Suthard / Wife 7024 Edgemont Rd. Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Jan. 29 2009 Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of The Hervice License Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician seconds disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** minutes/hour Sequentially list conditions, if any, leading to immediate cauca, and industrying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Day Ye ar 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ ₩6 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2. No 1 ☐Yes 2 ☐No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) House 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MD

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

y un 32. Registrar's Signature DO0 67442

Thomas Johnson Drive, Frederick, MD

21702

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			1- For State Registrar		4)	<i>Ce</i>	ertificate d	or Death			Reg 2. Date of Death	g. No.		3. Time of Death
Medic	Physicia al Exami	1117	1. Decedent's Name (First, N							ľ		Dav Year		2235 hrs
-	ar Exami		Kathleen Mari	e Sa	daler /e street and nur	nber)		4b. City, Town	or Location	of Death	1 ebitaly 0,	4c. County of	f Death	
			Howard County Ge	_		,		Columbia	1			Howard		
	Funeral		5. Social Security Number	6. S	ex	7. Age (In yrs.	last birthday)	If Under 1		er 24Hrs.	8. Date of Birth	(MM/DD/YYYY)	g. Birth Foreign	place (State or
	Director		215-48-9199	1	M ZXXF	5	9 Y	rs. Months [	Days Hours	Min.	4-18-1	949	Cour	ntry) <b>NY</b>
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9	e Maryland or 28a-f show hed at once.	Director	10e. Street and Number 5970 Apt. 3	harma	bout In			10f. Zip Cod 21044			109	g. Citizen of What USA	at Courit	ıy:
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	ath wi	Funeral	11. Marital Status  1 Never Married 2	Married	Armed Fo	F		Yes, specify Cu				White		an indian, black,
	ter de		3 Widowed 4		1 Yes d If Yes, Give Year	2XX No	1	Yes 2 X	No specify.	:		Specify: \	Whit	e
	urs af	d b	15. Decedent's Education		or Dates:			ent's Usual Occi				16b. Kind of Bus	siness/In	dustry
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	permit Page Department (Important: injury or otl	1	4 Donation 5 Oth	pecify vice Lice		<u>I A</u> 1411	raent (	<u>Crematic</u> Name and Add	<u>)N</u> ress of Facilit	V Har	0-2009 J	Hanove:	E'am	ily FH, Inc
ä	Den Tiji		Vilet Va	el-	MO	1411		4112 Old	Colum	ila. ibia	Pike. E	11icott	Cit	y, MD 21043
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	/Medical xaminer		Immediate Cause (Final dis		Verapa	mil &	Alprazo	lam int	oxicat	ion			IC.	Death
	X AIIIIII OI		or condition resulting in dea	th)	Due to (or as a	consequence	of):							
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	r Atter de irecte	fica	2 Accident 3 Suicide 6 X	Investiga Could no	28e Plac	e of Injury - Al	home, farm, s	treet, factory, off	ice building, e	etc.	28f. Location (S	Street and Number	er or Rui	ral Route Number, City nabout Ln.
É	nital o	Certification:	4 Homicide	determin		house					#3"Colu	mbia, M	Drui	nabout In.
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physi Examin	cian: To the bes er:On the basis	of examination	edge, death oc n and/or invest	curred at the tim	e, date and p nion, death o	lace, and occurred a	due to the caus t the time, date a	e(s) and manner and place, and d	as state	ed. e cause(s)
	To To Com	Med	29b. Signature and title of c		and manner s	tated.			cense numbe			29d. Date sign		
		-	Wall mis	M	e Mari	2			.C.M.E.			February 7	, 2009	
7	5.2		30. Name and address of p	rson who	completed caus	se of death (It	em 23a)							
<u>(</u>			Margarita Korell N	D. A	ssistant Med	dical Exam	iner 111	Penn Stree	t, Baltimor	e, MD 2	21201			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

FR 1 2 2009 June 6.

Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Censura

,) Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 04259 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Month **Physician** Ralston Snowden 12:55 P M February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 304 Farm Road Harford Aberdeen If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F Illinois Director 351**–**32–9564 73 Nov, 9, 1935 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director Aberdeen Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 USA 304 Farm Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates:1 958–1985 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) military US Army 4 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Rolen Snowden Duzzaa Ralston 19a. Informant's Name/Relationship (Type. Print) 21814 Winsome Rose Court, Cypress, TX 77433 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Gerald Snowden (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 3 ☐Removal from State Bushnell Cemetery Feb 10, 2009 Bushnell, Illinois 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.7 333 S. Parke St., Aberdeen, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Obstructive tulmonary hronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronav 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami ascular revolvera that initiated events attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 2 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

Registrar が<sup>よい</sup> DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMAN

Year)

52 32. Registrar's Signature 00036

29d. Date signed (Month, Day, Year) February 6, 2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009

		•	For State Registrar	State of Marylan		rtificate of De		entai riyy R	eg. No. 2	009	04260
	Physicia	an	Decedent's Name (First, Middle, Las     ELEANOR	B. TUR	NER			Date of Deat Month	Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, giv			4b. City, Town, or Lo	ocation of Death	JANUARY		2009 nty of Death	7:10 P "
	Examili	CI	MANOR CARE NURS	ING HOME		LARGO	)		PRI	NCE GE	ROGE 'S
	Funeral		Social Security Number     6. S	ex		If Under 1 Year		8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign try)
	Director		275-40-4466 Usual Residence of Decedent	UW 2541 00	Yrs.			JULY 28	1942	CHI	CAGO ILL.
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10	d. Inside City Limits
	a-fsh	ctor	MD PRINCE G	EROGE'S F	T WASH	INGTON					1 Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Count	try?
	sath w	eral	436 ROSIER ROAD	12. Was Decedent Ever in U.	c 12	20744	anic Origin? (Spec	cify Vas or No-	USA	Race - America	an Indian
_	fter de	<b>Funeral Director</b>	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?  1  Yes 2 No If Yes, Give		Was Decedent of Hisp If Yes, specify Cuban,		Rican, etc.)		Black, White, e	
000	be filed within 72 hours after death with the Maryland and Hylgiene.  Id hylgiene.  Id other than "natural", or items 23a or 28a-f show event, I've Medical Everying must be notified at	by	3 Widowed 4 Divorced	If Yes, Give** Year or Dates:		1 □ Yes 2√∑ No	Specify:		Spe	cify:AFRI	CAN AMERICA
ה	72 hg	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupation  kind of work done dure  DO NOT use retired)	on ing most of workin	g	16b. Kind of	Business/Ind	ustry
V	within ene. than	duc	Elementary/Secondary (0-12) 1 2 TH	College (1-4or 5+)		CEPTIONIST			יחת.	TIAME	
0	filed Il Hygi other rent, I	BeC	17. Father's Name (First, Middle, Last)	,			8. Mother's Name	(First, Middle, N		LVATE name)	
/lai	should be nd Menta marked imatic ev	To B	GEORGE W. TURNE	R			MARIE	TTA T	URNER		
lar	is a		19a. Informant's Name/Relationship (	• • • • • • • • • • • • • • • • • • • •		ng Address (Street and			•		•
و ف	s 1 and of Health Item 27 other tr		RUTH T. PEROT/SI  20a. Method of Disposition			ROISER ROA				YLAND 2	
<u> </u>	Pages ment of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemovai from State	-	osition (Name of matory or other place) E CREMATOR				ŕ	
ащто	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Liçer		V LKDAL 2	2. Name and Address	of Facility .I.	B. JENK	KIVERI TNS FI	INERAL.	ARYLAND HOME
ă	any per		K.D. M La			7474 LANDO					
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deatl one cause a each line.	. Do not en	ter the mode of dying,	such as cardiac or	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Brot		MULT	My			10	Onset and Death
-	/Medical Examiner		resulting in dealts)	Due to or ella consequence	uence of):	sh				,	- 10
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or se a conecq	uenes offi	1000	122.5			- 1	,30-1
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68/60,	tificate be executed g physician and as the burial-transit	ledical		d		····			<del></del>		
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Ď	death	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		☐ Ectopic pregnancy ☐ Other (specify)				Month	Day Year
7. O	at the d by th etache	Phys	9 Unknowh		dans in the c		in Doubl	22a Did tob	2000 USO O	ontributo to th	e cause of death?
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Hecord	v requ been should	letec						24a. Was a			osy findings available
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Vital	lan: T	a	25. Was case referred to medical			2	6. Place of Death			1 ☐ Yes	2 12/110
01 <	hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐			4∏Nursing Hom	ne 5 🗌 Reside	nce 6 🗆	Other (Specify	)
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VISION	Attenc death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not b	28e. Place of Injury - At ho	ome, farm, st			8f. Location (St	reet and Nu	mber or Rural	Route Number,
<u> </u>	al or A s after al Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Specif	y)			City or Town	, State)		
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example Medical Example 1	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the time ovestigation, in my opin	, date and place, a nion, death occurre	and due to the c ed at the time, d	ause(s) and ate and plac	I manner as st ce, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1 //		29c. License n	number	2	9d. Date sig	ned (Month, L	Day, Year)
			M	1/28		DS	7261	0	11-2	7-7	009
$\wedge$	4		30. Name and address of person who	17							
1	Sta	40	RICHARD FELDM. 31. Date filed (Month, Day, Year)	AN M.D. 9500 32. Registrar's Signa		LIS ROAD #	A-4 LAN	HAM, MAR	YLAND	20706	
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10a-f, & 18 per Inf G904 6/2/10 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04261 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Millicent Mary Timpanaro JəMübry 25, 2009° 00:25A. м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 30, 1927 9. Birthplace (State or Foreign Funeral 1 □ M 2√2 F Months Days Hours Min. New Jersey 141-20-7914 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Eventinar must be nedfled at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Morvland-Churchton - <del>Anne Arundel</del> 1 XYes <del>2X No</del> Funeral Director Florida Broward Plantation 4 8 1 10f. Zip Code **33317** Street and Number 9th Street 10g. Citizen of What Country? United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2√□ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Self Employed Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fiorello Francis Pennetta Bessie Morris <del>McGilicuty</del> ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5518 Ilchester Street Churchton, Maryland 20733 William Francis Timpanaro -son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MetropolitanCrematory 1/31/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Boliald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee Þ 4400 Powder Mill Road Beltsville, Maryland20705 comas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on \_ich line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VISCUS an 13 /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □Ne 1 ☐ Yes 2 ☑ No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi funeral of 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: Aft
pletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖳 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 2001 Park way Apricalo

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 29

2009

37 Registrar's Signature

State of Maryland / Department of Health and Mental Hygien? 009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** OTIS TOWNSEND, JR. W. 6:02 A M 28, 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crisfield Somerset McCready Memorial Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 TXM 2 □ F Yrs. 218-24-4355 81 Director Nov. 6, 1927 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2X No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be n 21817 U.S.A. 26703 Johnson Creek Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. r than "natural", or iter the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner-Mechanic Auto Parts 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otis W. Townsend Mabel Hurley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 26703 Johnson Creek Road - Crisfield, MD Vera Townsend (Wife) 21817 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any Injury or o
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Sunnyridge Memorial Park 1/31/09 Crisfield, MD 21. Signature of Fune Service Licensee 22. Name and Address of Facility Robert Bradshaw & Sons Funeral Home H Bradshaw 306 W. Main St. - Crisfield, 16 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DEMENTIA. ALZHEIMERS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) signed by the a I Yes 2 □ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown SCVD. 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has le 2 rector, page 2 ral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 48098 28/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Thelma Jones Trego 2/6/2009 10:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 913 Talisman Lane Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Year) 1 □ M 2 💢 F 3/29/1925 83 **Director** 214-12-5944 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Madical Evaminer must be notified at 1 XYes 2 No Director Cambridge Maryland Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 913 Talisman Ln. 21613 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Mango. Elementary/Secondary (0-12) College (1-4or 5+) Beautician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orlie B. Jones Nellie Windsor ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin E. Trego / Husband 913 Talisman Ln., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/10/2009 4 □ Donation 5 □ Other (Specify) Eastern Shore Veterans Cemetery Hurlock, MD 22. Name and Address of Facility 21. Signature of Funeral Curran-Bromwell Funeral Home, P.A., 308 High St. Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician dementia Utars /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ M 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1∐ Yes 27. Manyer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Machinian Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St, Cambridge a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State H 1 2 ZUUS Registrar

DIL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Z PMM THELMA , 2009 may ( UMBER GER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD HOWARD COUNTY GENERAL HOSPITAL COZUMB 1A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year) June 22, 1906 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2√□ F Virginia 212-20-1330 102 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Department of Health and Mental Hygiene, Informative items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at another. Maryland Howard Woodstock 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11048 Doxberry Circle 21163 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify. White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Safeway 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Samuel Tilden Harmon Ella May Groseclose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine U. Garofolo -Daughter 11048 Doxberry Circle Woodstock, Maryland 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Oak Cemetery 1/28/2009 4 □ Donation 5 □ Other (Specify) Gaithersburg,Maryland 21. Signature of Funeral Service Licensee Dốnalđa Viesofski protesti Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician RESPIRATING FAILURD AWTÉ 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 20 days NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death.

• eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYSCARDIAZ INFARUTUM 1 🗌 Yes 2 No 3 Probably 4 Unknown CIMUMIC NOTHER INSUFFICIENTY 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed thy PERTONSION 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 36974 JAN 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAND ONYANJOM 10724 LITTIE PATOKENT PARKNAM Councia 31. Date filed (Month, Day, Year)

JAN 29 2009 2. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar	nd / Depa <i>Ce</i>	artmei <i>rtifica</i>	nt of Hea te of De	alth and I eath	Mental Hy	giene Reg. No. 2	009	04265
П	Physicia		1. Decedent's Name (First, Middle, Last)		Vin	es			2. Date of De Month Januar	Day	, 2009	3. Time of Death 1855 M
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)	01.0	-	, Town, or Loc	cation of Death		-	ounty of Death	
p-1	Funeral	G1	Larkin Chase He 5. Social Security Number 6. Sex	7. Age (In yrs.				Under 24 Hrs.	8. Date of Bir	Pri	9. Birth	eorges
	Director		246-52-0096	<sup>1M 2</sup> 73	Yrs.	Months	Days F	Hours Min.	May 5	1935	Nort	th Carolin
	D 3		Usual Residence of Decedent  10a, State 10b. County	10c Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Aaryla f sho	ō	MD Prince G			nham						1 X Yes 2 □ No
	the N	Director	10e. Street and Number		Бал		p Code			10g. Citizer	n of What Cou	untry?
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	ems S	Funeral		12. Was Decedent Ever in U Armed Forces?	.s. 13.	Was Dece			pecify Yes or No Rican, etc.)		Race - Amer Black, White	
36	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, I've Mariteal Evania at rust be notified at	by Ft	1 Never Married 2 Married	1 □Yes 2 No If Yes, Give		1 □Yes		Specify:			pecify:	
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15	nin 72 In "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of w		ng most of work	king			,
212	filed with Hygiene ther tha ant, the	Com	12	Conlege (1-401 5+)		Nu	rse			P	rivat	e
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yla y	2 should be filed and Mental Hygi Is marked other aumatic event, II	၉	Charlie Graham		1			Cora	Grahai			
Ma	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship (Ty) Theresa Vines/De	,	2411	Ma Ma	s (Street and thew	Henso	n Aven 20785	er, City or 16 .ue	own, State, Z	ip Code)
ē,	s 1 and 2 should of Health and Mer item 27 is marke other traumatic	1	20a. Method of Disposition		Place of Dispo cemetery, crei	sition (Na	me of		Date		tion - City or T	
e E			1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 1				orv 1/	29/09	River	cdale	.Md
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License									eral Home
m	B a E B		140		3	821	14th	Street	, NW, Wa	ashin	gton,	DC 20011
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat e cause on each line.	th. Do not en	ter the mo	de of dying, s	such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
F	hysician		Immediat Cause (Final disease or condition resulting in death)	Dementia								Oliset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):							
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		/Me	IF FEMALE:	3c. If yes, outcome of pregn	ancv					004		
Box	law requires that the death cert as been signed by the attendin 2 should be detached for use s	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 🕅 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	al death 3[	☐ Ectopic ☐ Other (s	pregnancy pecify)			230	d. Date of deli Month	Day Year
P.O.	t the c by the achec	hysi	9 Unknown	9 🗌 Unknown								
S, F	uires that the de	by P	Part il. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying	cause given ir	n Part I.	23e. Did	tobacco use	contribute to	the cause of death?
ord	w require been si should b								1 🗆	Yes 2 N	√o 3∏ Pro	obably 4 XUnknown
ec .	law r has b	Completed							24a. Was auto	psy	prior to c	topsy findings available completion of cause of
<u> </u>	icate h								1 □ Yes		death? 1 ☐ Yes	2 [ <b>X</b> No
<u> </u>	Physician: The lav this certificate has al director, page 2 g	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatient 2 ☐	1500		Othor		th (Check only		70	
Division of Vital Records,	ding Phy n. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o		28c. Injury at Work?		ome 5 Res			cify)
<u>o</u>	nding Fath.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	М		s 2 □ No				
NIS	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director, to	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	reet, factor	y, office		28f. Location ( City or To	Street and N wn, State)	lumber or Ru	ral Route Number,
ה ו	ital o urs aft rai Di											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical		sician: To the best of my kno ner: On the basis of examina and manner stated.								
	To the within To the compl	Me	29b. Signature and title of certifier	<b>A</b> .		29	lc. License nu	umber		29d. Date s	signed (Month	n, Day, Year)
	7/			M,			D4521	L <b>7</b>		1/2	28/09	
			30. Name and address of person who co	11								
			Ade Isaac Ajay:	M.D. 620  32 Registrar's Signa		enbe	elt Ro	oad #M	18, Co	llege	Park	,MD 20740
	Sta Registr		31. Date filed (Month, Day, Year)	negistrar's signa		100						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. <sup>D</sup>2009 21, 1312 p Vaden Henry Ε. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Cheverly Prince Georges Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 6, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last hirthday) 6 Sex Months Days Hours Min D Country 1 □**X**M 2 □ F 65 577-56-0886 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Capitol Heights Md. Prince Georges Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 20743 1018 Mornington Place U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates: 1 Yes 2X No Specify. 3 Widowed 4 Divorced 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pepsi Company Fork-Life Operator 12th 18. Mother's Name (First, Middle, Maiden Surname) Susan McNeil 17. Father's Name (First, Middle, Last) John Vaden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 (Wife) 1018 Mornington Place Capitol Heights, Md. Helen E. Vaden 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 XBurial 2 ☐ Cremation Lincoln Memorial 01/31/2009 Suitland, Md. 4 Donation 5 Other (Specify) Name and Address of Facility . H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, DC 20010 23a. Part 1. Inter the disease, or complication shock, or heart failure. List only one commediate Cause (Final Approximate Interval Between Onset and Death s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Hypertension disease or condition resulting in death) Due to (or as a consequence of): Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): End-Stage Renal Failure Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🔯 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 TyNo death? 1 ☐ Yes 2**√** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

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items 23a death v

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

Examiner must be notified at

event, the Medical

Director

Funeral

2

Completed

Be

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with the Maryland

/Medical

burial-trar physician as the burial page 2 After 124 hours after death.

Refered Director: 4

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

n/Medi
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complete
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Examine ca Certification

within 2

	Sta Registr	31. Daye filed (Month
R	5	30. Name and address Gary Lit

Medical

27. Manner of Death

1 XNatural

2 Accident

3 Suicide

29a, Certifier

29b. Signate

4 Homicide

(Check only one)

Year)

5 Pending investigation

6 Could not be

determined

D58957 of person who completed cause of death (Item 23a) (Type, Print) :tle, M.D. 3001 Hospital Dr.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Cheverly, Md. 20785

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Jan. 22, 2009

Date of Injury (Month, Day, Year)

and manner stated.

28c. Injury at Work?

15 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

		1	For Stata Registrar	1 1000	Si	ate of I	Marylan		artmen tificate			and M	ental Hy	giene Rog. Na	00	9	042	67
£	Physicia		1. Decedent's Name Bertha	(First, Middle,	Gra		\	/ipond					2. Date of Dea Month Feb 6	Day	na Y	'ear	3. Time of 0900	Death
	/Medic Examin	al -	4a. Facility Name (If r	not institution,				пропа	, ,		Location of	of Death	1 65 0	4c.	County of	Death	0000	
14 (E)	4	_	Frostbur					last birthday)	Fro If Under	stbu	rg If Under	24 Hrs	8. Date of Birt	_	llega	ny Birthol	ace (State o	r Foreign
46	Funeral Director		5. Social Security Nur 181-26-0		i. Sex 1 ☐ M	2□₹ /.	77	Yrs.	Months	Days	Hours	Min.	Feb 5	, 193	32	Count	ace (State of try) PA	· · · · · · · · · · · · · · · · · · · ·
	and w	F	Usuaf Residence of D	Decedent 10b. County			10c. Cit	y, Town or Lo	cation							10	Od. Inside Cit	ty Limits
	the Marylar 28a-f ehow	tor	MD	Alleg	gany			LaVa	ale								1 □XYes	2 No
	within 72 hours after death with the Maryland ene. Than "naturel", or Iteme 23e or 28e-f ehow he Medical Examinet must be notified at	Funeral Director	10e. Street and Numl		Day	Pood			10f. Zip	Code	2150	2		10g. Citi:	en of Wh		try?	
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98	or ite	y Fur	1 Never Marrie		d	Armed Force □ Yes 2 f Yes, Give	□XNo		nr res, spek 1 ∐ Yes		Specify:		Alcan, etc.)		Specify:	whi		
21215-0036	2 hours aturel',	ted by		Divorced  15. Decedent's	Education	Year or Date	95:	16a. Dece	dent's Usua	al Occupa	ation	4 a6adi		16b. Kii	nd of Busi			
215	ithin 7. ne. nan "n	Completed	(Specification)	y on <i>ly high</i> est dary (0-12)	T	mpietea) Colfege (1-4	or 5+)	life.	kind of wo	se retired	ning mos ()	COI WOIKI	iig	doc	gror	nmir	na	
N	filled w Hygier other ti ent, the		17. Father's Name (F	irst, Middle, L	ast)			owne	i/opei	alui	18. Mothe	er's Name	e (First, Middle,				19	
ylan	ould be Mental larked o	To Be	Samu	el Spea	ring						EII		Spearing					
Maryland	od 2 sho lith and 27 le ma		19a. Informant's Nar Ernest V	ne/Relationshi 'ipond	р (Турв,		sband	19b. Maili 100	ng Address 28 Sho	ortest	Day R	oad	LaVa	ar, City o ale	r Town, St	tate, Zip MI	D 215	02
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiens. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at any injury or other traumatic event, the Madical Examinar must be notified at ance.	1	20a. Method of Dispo 1 ☐ Hurial 2 ☐ 4 ☐ Donation	Cremation		oval from St		Place of Disponentery, creestlawn	matory or o	ther plac		C	2/10/200		cation - Ci Vale	ity or To		MD
Balti	permit. Departm Imports any inju		21. Signature Fun	///	1/	11	1		1(	08 Vir	ginia A	venu	e: Cumbe	erland	, MD :	2150	2	
	Physician /Medical Examiner physician and physician and	Examiner	21. Signature of Fundral Service Ucen ee  22. Name and Address of Facility Scarpell of Fundral Home, PA 108 Virginia Avenue: Cumberland, MD 2  23a. Part 1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.  Immediate cause (Final disease or (condition resulting in death)  Due to (or as a consequence of):  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												Approximation finterval Betronset and I	ween		
P.O. Box 68760	death certificate e attending phys d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 I 1 Yes 2	nonths?	d 23c.	1 Live bird	ome of pregn th 2 ☐ Feta nt at time of o	al death 3	⊒Ectopic p ⊒ Other (sp		1				23d. Date Monti	h	Day '	Year
	ires tha signed I be det	ρ	Part fl. Other signifi	cant condition	15 contrib	uting to dea	th but not res	sulting in the i	underlying (	cause giv	en in Part	l.			ise contrib □ No 3		ne cause of coably 4	death? Unknown
Vital Records,	: The law requires that the cete has been signed by th page 2 should be detache.	Completed											24a. Was auto perfo 1 - Yes		pri	ere auto ior to con ath? Yes	psy findings mpletion of c	available cause of
	Physician: Th rthis certificete ral director, pag	o Be	25. Was case referrexaminer?		Hos	oital:	patient 2	] ER/Outpatie	ent 3□ D	OA Oth			h <i>(Check</i> on <i>ly i</i> ome 5 ☐ Resi		6 ∏Other	(Specif	v)	
n of	ding Phy I. After this funeral o	<b>—</b>	27. Manner of Death	5 Pending	,	28a. Date of (Month		28b. Time Injury		28c. Injur Wor	y at k?		28d. Describe					
Division of	Attending death	Certification:	2 Accident 3 Suicide 4 Homicide	investig 6 □ Could n determi	ot be	28e. Place o building	of fnjury - At h g, etc. <i>(Spec</i>	nome, farm, s			Yes 2	1140	28f. Location ( City or To			r or Rura	il Route Nun	nber,
	Hospital or 24 hours afte Funerel Dir itely filled in	Medicai C	29a. Certifier (Check only one)				sis of examin						and due to the red at the time,					s)
	To the within 2 To the comple	Med	29b. Signature and	title of certifier							se number				-		Day, Year)	
			1 wor	recy	ES	hu	i M	10.		000	553	325		Fe	6 09	, 2	009	
			30. Name and addre	ess of person	who comp	eleted cause	of death (Ite	ESHOP	Print) WAL	SH I	RD (	ium	berlan	d	MD=	215	02	
154	St Regist		31. Date fifed (Mont	Dey, Year)	2 200	32. Re	gistrar's Sign		bark	A								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ralph L. Warren January 23, 2009 11:35 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genesis Crescent Cities Prince George's Riverdale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, 6 Sex **Funeral** 1 XM 2 ☐ F Months Days Hours Min 2-11-1934 Raeford, Director 241-44-2483 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be modified at XXYes 2 □ No Director MD Prince George's Hyattsville with the 10f. Zip Code 20872 10e. Street and Number 10g. Citizen of What Country? 908 Luray Place United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever In U.S. Armed Forces?

1 ∑Xes 2 □ No 1952 ─ If Yes, Give Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2√□No Specify **Black** Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private f Health and Mental Hygier them 27 is marked other the other the other traumatic event, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Warren Blanche Haley မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomasene Mason ( sister ) 526 Petty St. Petersburg, VA 23805 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot QRICE. 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 1/28/2009 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home whit 3401 Bladensburg Rd. Brentwood, MD 20722 tron 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Artery Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ Heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed Kidney failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Atrial fibrillation 1 ☐Yes 2 ☐ No 1 □Yes 2√□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 □Yes 2 □No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and reley filled in by the funeral director, page 2 should be detached for use as the burial-transit n 24 hou.. the Funeral Dire

Medical within 2 To the Registrar

State

29a, Certifier

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saadia Husain, MD 31. Date filed (Month, Day, Year)

JAN 2 9 2009

32. Registrar's Signature

and manner stated

🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 0064208

Riverdale, MD 20737

29d. Date signed (Month, Day, Year)

1/27/2009

			For State	State of M	aryland					and M	ental Hy	giene	000	0	0.1	270
			Registra/AMEND# 16a/bp		W,MbCo	Cer	rtificate	of L	Death			Reg. No	200	19	U 4	270
I	Physici		1. Decedent's Name <i>(First, Middle, La</i> Jackqueline J	<sub>ast)</sub> eanette Wi	.der						2. Date of De Month	ath Da 17	y Ye 200		3. Time of 12:00	
-	/Medio		4a. Facility Name (If not institution, gi	ve street and number,	)		4b. City, T	own, or	Location of	of Death			. County of E		12.00	
4			Holy Cross Hosp	ital 1500	Forest	t Gle	n Silv	er	Sprin	g MD			Montgo	mei	Э	
	Funeral Director			Sex 7. Ao 1 □ M 2√2 F	ge (In yrs. las 58	st birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 08/06	th 17. Year) 195	9. 0 V	Birthpl Coun A	ace (State of	or Foreign
	pu ,		Usual Residence of Decedent		1.0.00											
	aryla shov	7	10a. State 10b. County			Town or Loc								10	)d. Inside C	aty Limits 2 □ No
	the M	Director	DC  10e. Street and Number		Wa	ashing	gton D					10= 0	tizen of What	Count		
	with ga or			NT T.7				001				-		Couri	ıyı	
	ns 23	Funeral	756 Harvard St.	12. Was Decedent	Ever in U.S.	13. V			spanic Ori	gin? (Spe	cifv Yes or No		SA 14. Race - A	merica	an Indian.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates:		1	fYes, sp <i>e</i> cif □Yes 2		Specify:	i, Puerto F	cify Yes or No Rican, etc.)		Black, W Specify: I	hite, e	tc.	
9-0	2 hou	Completed	15. Decedent's E	ducation		16a. Deced	lent's Usual	Occupa	ition			16b. K	ind of Busine	ss/Ind	ustry	
21	thin 7 e. an "r	nple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	kind of work	retired)			-	wası	hingto d Hosp	n E	lome	
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Maryland	be fill htal H ad oth even	Be	17. Father's Name (First, Middle, Las.								(First, Middle,					
ž	d Mel marke	2	William Henry J			401 14 11					oberta					
Ma	d2st than 7 isr traur		19a. Informant's Name/Relationship	,							Route Numb				Code)	
	1 and 2 Health em 27 i		Mary E. Wise /s	ıster	20b. Plac						ashing ate		DC 200 ocation - City		vn. State	
<u>lo</u>	ages ent of tr: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐				sition (Name natory or oth									
Baltimore,	permit. Pages 1 and in Department of Health Important: If Item 27 any injury or other troonce.		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		Sn.	LION I	Baptis Name and	Addres	s of Facility	1/23 v Mar	/2009   shall's	WO Fu	odvill peral	e , ۱. Hon	A le	
B	Depar Impor any in		J.P. May	shall							ashing					
	Physician /Medical		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each fi	<sub>ne.</sub> cysti	tis	er the mode	of dying	g, such as	cardiac o	respiratory a	rrest,			Approximat Interval Bet Onset and I	tween
	Examiner	er	Sequentially list conditions, if any leading to immediate	b. Klebs Due to (or as	siella a consequer		ary tr	act	infe	ctio	n					
8	ficate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Acute 1	respir	atory	failu	ıre								
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P.O. Box (	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal de	eath 3 🗆	Ectopic pre						23d. Date of Month		•	Ye ar
	ires that signed t	<u>م</u>	Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the un	derlying cau	use give	n in Part I.				use contribut			
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of Vital Records,		Completed									24a. Was autor perfo 1 □ Yes		l death	17	sy findings apletion of c 2 <b>Y</b> No	ause of
/ita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ne)				
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sion (	ending ath. or: After ne funer	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		iry 28 ly, Year)	8b. Time of Injury	M 286	c. Injury Work? 1 🗆 Y	at ? ′es 2 □ l		8d. Describe I	now injur	y occurred			
Division	tal or Attendliss after death.  al Director: A ed in by the fu	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At home c. <i>(Specify)</i>	e, farm, stre	et, factory, o	office		2	8f. Location (S City or Tov	Street an vn, State	nd Number of	Rural	Route Num	iber,
	Hospit 24 hour Funer tely fill	Medical (	29a. Certifier (Check only one)	hysician: To the best miner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred a restigation, i	t the tim	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s date and	) and manne d place, and	r as st due to	ated. the cause(s	;)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1			29c.	License	number				te signed (M	onth, E	ay, Year)	
	3		MA	De la companya della companya della companya de la companya della		***		D65	953			1/	19/09			
			30. Name and address of person who	completed cause of o	leath (Item 2		Print)			- I			-4			
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signatur	150	o Fo	res	:+ (	a len	RISII	VEX	Sp	-IN	g; MI	>
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State of Maryland / Department of Health and Mental Hygiene	n	N	9	
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			State of Maryland / I	Department of Health and M Certificate of Death	ental Hygien	
	Dhamini		Decedent's Name (First, Middle, Last)		Date of Death     Month     D	3. Time of Death
	Physici /Medio		Virginia Stephenson Walter		January 1	8, 2009 6:40 AM
1	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
John St.			Heartland House Asst. Living	Grasonville		nne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	Director		377 10 7302 11 67	Yrs.	lug. 8, 19	21 Virginia
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	larylt r sho	ō		ellville		1 □Yes 2 🕅 No
	28a-	ect	Virginia Loudoun Purce	10f. Zip Code	10n C	Citizen of What Country?
	with De or	Ö	20421 Cockerill Road	20132		.S.A.
	ns 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.			14. Race - American Indian,
(0	riter	Ē	1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☑ No If Yes, Give 1	13. Was Decedent of Hispanic Origin? (Speilf Yes, specify Cuban, Mexican, Puerto F	Ricán, etc.)	Black, White, etc.
21215-0036	urs a		3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐Yes 2 😾 No Specify:		Specify: White
0-10	2 ho	ted	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation	16b.	Kind of Business/Industry
215	e. an "r	ple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	9	
21	d wil	Completed by	2	Teacher	Ed	ucation
nd	at Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	en Surname)
<u>ya</u>	Meni the arked	ပ	David Stephenson	Meta Und	lerwood	
Maryland	2 shc and is m			o. Mailing Address (Street and Number or Rural		
2,	and lealth m 27 her tr			00 Broad Creek Dr., St		-
ore	H of H		20a. Method of Disposition 20b. Place o cemete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	f Disposition (Name of Darry, crematory or other place)	ate 20c. I	Location - City or Town, State
Ë	ment ment mant:		4 Donation 5 Other (Specify) Friend	ls Cemetery 1/22/	09   Li	ncoln, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rectified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hall Funeral Home P.O. Box 896 Purcel	1willo V	A 2013/
			23a. Part 1. Enter the disease, or complications that caused the death. Do			Approximate
	Physician		shock, or heart failure. List only one cause on each line.	That Earling		Interval Between Onset and Death
,	/Medical		resulting in death)  a. Due to (or as a consequence	VENT   NITUIG		
The sail	Examiner		(Annon meraly	-		
		Je.	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence	of):		
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	TIPE		
Ć,	exec	Exa	resulting in death) Last  Due to (or as a consequence	of):		
)9/	te be ysicia e bur	cal				
68	tifical g ph as th	edi			1	
Box 68760,	eath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	0.00		23d. Date of delivery
m	deatl e atte d for	icia	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	at the de I by the stached	hys	9 Unknown			
, E	es tha igned be det	by P	Part Ii. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part i.	23e. Did tobacco	use contribute to the cause of death?
ğ	w require been sig should b				1 ☐ Yes 2	2 ☐ No 3 ☐ Probably 4 🔀 Unknown
Records,	law re as ber 2 sho	Completed			24a. Was an	24b. Were autopsy findings available
æ	The la	E			autopsy performed?	prior to completion of cause of death?  Io 1 □ Yes 2 □ No
Vital	siclan: Th certificate rector, pag	Be C	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 ☒ N	TI Yes 2 INC
<u>&gt;</u>	rysici iis cer direc	To B	examiner? 1 ☐ Yes 2 ☒ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou		·	6 Mother (Specify) Assisted Liv.
	ding Ph h. After th funeral	n:T	27. Manner of Death 28a. Date of Injury 28b.		8d. Describe how inju	
Ö	Attending ir death. ector: Afte by the fune	atio	1 I Natural 5 □ Pending (Month, Day, Year) 1 2 □ Accident investigation	M 1 Yes 2 No		
Division	il or Attend after death   Director: , d in by the f	ific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	rm, street, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
Ö	al or s afte al Dir ed in	Certification:	Full Holling Cit. (Opcony)		City of Town, Sta	(10)
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier (Check only (Ch	e, death occurred at the time, date and place, a	nd due to the cause	(s) and manner as stated.
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	one) and manner stated.			
	with Vaith Con Con Con Con Con Con Con Con Con Con	Σ	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
			Special Williams	DD0 41 055	/	120/00
A	10		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)  Letnel. Br		1 - 11 -
K	, 10		Joel Wilkerson 204 medie	el ctn Rd. For	nsonve	lle mel 2163
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature.			

**ORIGINAL** 

DHMH 17 Rev 1/2001

21215-0036

Box 68760.

Ö

of Vital Records.

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 0150 AM AA)CJan. 26,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Schöbury Rehabilitation & Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Salisbury Vicomico 8. Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 X F Days Hours 48-60-602 Director Usual Residence of Decedent the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Items 23a by Funeral Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 215-0036 'natural', or 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seçondary (0-12) College (1-4or 5+) Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Mental e11 FENG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traconce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 22. Name and Address of Facility  $\mathcal B$ Service L ensee Poco 23a. Part1. Enter the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause an each line. disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** d angery. ERI /Medical Due to (or as a consequence of): Examiner 000-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as consequence of): physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical ate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 1 🗆 Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 40 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Anatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Directors, 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

BA3

State Registrar

DHMH 17 Rev 1/2001

Registrar

William

31. Date filed (Month, Day, Year)

JAN 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robins, M.D.

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No. 2009 042	1
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year	
	4a. Facility Name (if not institution; give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
Funeral	Doctors Community Hospital  Lanham  Prince George's  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or	
Director	217-23-7784 1 X M 2 F 22 Yrs. Months Days Hours Min. June 12, 1986 Foreign Washington D.C.	on,
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	
f show	Maryland Prince George's Greenbelt 1 Yes 2 X  10e. Street and Number 10g. Citizen of What Country?	No
the Maryland a or 28a-f she tiffed at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  7564 Mandan Road 20770 U.S.A.	
r death with the or items 23a r must be not	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Meinal Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show or other trannatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	S Wildwell 1 To Specify. Asian	
2 hours "natun Exam		٠.
5-0036 iled within 72 hour liggiene. I tygrene. I other than "natur the Medical Exam Completed	12 Student School	
215-C be filed v intal Hygi rked oth ent, the Be Co	D v v v v v v v v v v v v v v v v v v v	
212 nould be and Menta is mark tic even		
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	Harry Yudhistira Tirtakusumah - Fathet 7564 Mandan Road, Greenbelt, Maryland 20770  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town, State	
5 2 2 2 2	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: A1-Firdaus Memorial Garden 02/06/2009 Frederick, Maryland	
Baltimo permit. Page Department of Important: injury or ott	21. Signature of Funeral Service   Censee   22. Name and Address of Facility   Hines-Rinaldi Funeral Home, Inc.   11900   Nov. Henry him Avenue, Silver Spring Maryland 2000	
Physician	23a Part Linter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure_tist only one cause on each line.  Aparture 11500 New Hamilpshifte Avenue, 511Vel 3pring, 1147Vel 3pring, 11500 New Hamilpshifte Avenue, 511Vel 3pring, 1147Vel 3pring, 11500 New Hamilpshifte Avenue, 511Vel 3pring, 11500 New Ha	val
/Medical yaminer	Immediate Cause (Final disease a. Gastrointestinal hemorrhage Death	
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
red Insit	if any, leading to immediate Due to (or as a consequence of):  Cause. Enter Underlying Cause  (Disease or injury that initiated	
Exar	events resulting in death) Last  Due to (or as a consequence of):  d.	
50, te be executed by sician and burial - transit	Xunpended 23a,PII,27,perME, g890 4/6/09 TT	
8760, tiffcate being physicias the buri	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
box 68760, the death certificate be executly the attending physician and technical for use as the burial - rap Physician/Medical	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  9 Unknown  9 Unknown	
P.O. B res that the d signed by the be detached d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Aspiration pneumonia; seizure disorder  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknow	'n
ds, P.C equires that een signed ould be deta	24a. Was an 24b. Were autopsy findings availa	ble
Records, 1: The law requires ficate has been significate by page 2 should be Completed	autopsy performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No	)1
tal R cian: T certific ector, p	25. Was case referred to medical 25. Mass  _	
of Vifing Physic After this Cuneral direction To P	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other:	
ion creating leath.  tor: Af the fun	1 X Natural 5 Pending 1 Yes 2 No	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th roturs after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.  Certification: To Be Completed by P	3 Suicide 6 Could not be determined 4 Homicide 4 Could not be determined 5 At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or Rural Route Number, Country) 287. Location (Street and Number or Rural Route Number, Country)	ity
2		
To the IIc within 24 To the Fn completel	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
	O.C.M.E. February 4, 2009	
	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
I .	e 31, Date filed (//princ@ayYen) 2000 33 Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 21 per fh 888 2-13-09 vt. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 AMEND ITEM#18perFH\_C888, 2/17/09, WS Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year ALLEN FRANCELL 04 1255 PM 09 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Northwest Randallstown 5a it i more 5. Social Security Number 6. Sex. 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 11-9-1949 9. Birthplace (State or Foreign Year) 21.3-58-2662 Months Days Hours Min 59 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9620 Brie Court 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: African-American Specify. 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer State Highway Admin. 18. Mother's Name (First, Middle, Maiden Surname)
Simms
Grace Simmons 17. Father's Name (First, Middle, Last) George Allen Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacie Allen/ Daughter 9620 Brie Court Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Park 2-9-09 Eldersburg,, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wile Funeral home P.A. of Pallo. Co. 21. Signature of Funeral Service Licensee Brandon M. Wylie per dvr 9200 LibertyRoad, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic COLOUMA Artery disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **N**o 1 □Yes 2 **N**O 1 Tes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760. P.O. of Vital Records, **Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Modical Evanment must be notified at

**Physician** 

**Examiner** 

/Medical

burial-tra

physician the burial

attending p for use as as

signed by the a d be detached for

3altimore, Maryland 21215-0036

The law requires that the death certificate be executed Division

Completed by cate has this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 1 ☐ Yes Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 ☑ Natural 2 Accident 3 Suicide 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and the of certifier 29c. License number 1)0062650

29d. Date signed (Month, Day, Year)

Febuary 10th 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Craibs & 401 ord Court Road Randons town MD 21133 lanveer

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9

To Do Completed by Finders	To be completed by runeral Director
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Physician /Medical Examiner

M332

ARRIAGION-

P.O. Box 68760,

Division of Vital Records, J13337

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	For State Registrar	State of	Maryland ,	Depa <i>Cei</i>	artmer <i>rtificat</i>	nt of F te of L	lealth a D <i>eath</i>	and M	lental Hy	gien Reg. N	e2 (	09	04276
	1. Decedent's Name (First, Middle, Las	t)							2. Date of De				3. Time of Death
an	Cecelia F. Arrington								Month FEBRUAR		ay Z	2 0790	3:5578-M
al	4a. Facility Name (If not institution, give	street and nurr	iber)	-	4b. City.	Town, or	Location	of Death	0.5004,10			ty of Death	
er	/ /	SPITAL	,		R								
7	5. Social Security Number 6. Se		7. Age (In yrs. last	birthday)	If Under		If Under		8. Date of Bir	th		9. Birtho	lace (State or Foreign
	1	□ M 212 F	72	Yrs.	Months		Hours	Min.	(Month, Da 9/9/10	ay, Yea	r)	Cour	itry)
	112-34-5325 Usual Residence of Decedent		12						[ 5/5/ IS	<u> </u>		l MD	
	10a. State 10b. County	Λ	10c. City, T	own or Lo	cation							1	0d. Inside City Limits
ō	MD I	3											1 Yes 2 □ No
ect	10s Street and Number		Ba	ltimor	10f. Zip	Code				10a C	itizen of	What Cour	strv?
ä	10e. Street and Number				101. 24	Code				rog. c	AUZON OI	Wilat Coul	iti y :
<u>ra</u>	3710 Edmondson Avenu					21229					SA		
ű.	11. Marital Status	Armed Fore		13. \	Nas Dece fYes, spe	dent of H	ispanic Or ın, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	)-		ace - Americ ack, White,	
Ϋ́	1 Never Married 2 Married	1 ∐Yes 2 If Yes, Give	e <sup>2</sup> h		1 □ Yes	2/ No	Specify:				Speci	wAfric	an-American
q p	3 ☐ Widowed 4 ☐ Divorced	Year or Da											
ete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	1	(Give	dent's Usu kind of wo	rk done d	turina mos	t of work	ing	16b.	Kind of E	Business/Ind	dustry
du	Elementary/Secondary (0-12)	College (1-	4or 5+)		OO NOT u		)						
္ပြဲ	12th			_Cros	sing (	land,						re Cit	y
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)					1	18. Mothe	er's Name	e (First, Middle	, Maide	n Surna	me)	
2	Joseph Kirk						Mars	7 Star	nton				
i '	19a. Informant's Name/Relationship (7	ype. Print)		9b. Mailir	ng Address	s (Street	and Numb	er or Run	al Route Numb	er, City	or Towi	n, State, Zip	Code)
	Chanel Oliver / Gran	da phter		3710	Edmon	tenn A	venie.	Ralti	more, Ma	านโล	nd 21	22G	
	20a. Method of Disposition		20b. Place	e of Dispo	sition (Na	me of	a)		Date	20c.	Location	- City or To	wn, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		tate				i	2/4	2/2000	10-	3	1.4	7 3
	21. Signature of Funeral Service Licens		Metro	OLGIN	Name a	nd Addre	ss of Facili	<u>ا. /</u> اد آداداً ۱۷	<u>2/2005  </u>	ra 1 Lb		re, rai	yland Balto. Co.
	<b>I</b>								Eraeta Listown,				EUO. W.
	, vouis			-						-	y lock K	ندسلسا	Approximate
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	one cause on ea	iused the death. I ich line.	o not ent	er the mod	ae ot ayır	ig, such as	cardiac	or respiratory a	irrest,			Interval Between Onset and Death
	Immediate Cause (Final disease or condition	a	SEPTIC	_	SHO	OCK	_					3	7458
	resulting in death)	Due to (c	or as a consequen	ce of):									-
	Sequentially list conditions	b										2	
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consequen	ce of):									
ami	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
Ä	resulting in death) Last	Due to (d	or as a consequen	ce of):									
ca		d											
led	T.							-	C-C-C-				
N/	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy		7						23d. D	ate of delive	ery
Cia	in the past 12 months? 1 □Yes 2 □No	4 🗆 Pregn	irth 2□Fetal de ant at time of deat		☐ Ectopic <sub>[</sub> ☐ Other <i>(s</i> ;		y				M	onth	Day Year
Jys	9 Unknown	9 Unkno	own										
P	Part II. Other significant conditions co	ontributing to de	ath but not resultin	g in the u	nderlying o	cause giv	en in Part l		23e. Did	tobacco	use cor	ntribute to th	ne cause of death?
d b	toute KE	HAL F	FAI LUR	-5					1 🗆	Yes	2 🗌 No	3 Prob	bably 4 Onknown
ete	GASTROINT				150	70-			04- 14/		0.45	Mara auto	
du	70(3(00)01)	271117	V(C) ()	000	-1361	1 4			24a. Was		240	prior to co	psy findings available mpletion of cause of
ပ္ပ									1 □Yes	2	10	1 ☐ Yes	2 🗆 No
Be Completed by Physician/Me	25. Was case referred to medical examiner?					1		e of Deat	h (Check only i	one)			
ပ္	1 Yes 2 No		<del></del>		nt 3 🗆 D		4 LI N	ursing Ho	me 5 Res	idence	6 🗆 O	ther (Specif	y)
:uc	27. Manaer of Death 1 ✓ Natural 5 ☐ Pending	28a. Date o	of Injury   28 or, <i>Day, Year)</i>	<ul><li>b. Time of Injury</li></ul>	1	28c. Injur Worl	y at </td <td></td> <td>28d. Describe</td> <td>how inj</td> <td>ury occu</td> <td>irred</td> <td></td>		28d. Describe	how inj	ury occu	irred	
aţi	2 Accident investigation				М		Yes 2□	No					
iii	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place (	of Injury - At home	, farm, str	eet, factor	y, office			28f. Location ( City or To	Street a	and Num	nber or Rura	l Route Number,
Se.			3, ( , ),						,	,	,		
ia (	29a. Certifier 1 Certifying Ph												
Medical Certification: To	(Check only 2 Medical Exam	and mann		and/orin	vestigatioi	ıı, ın my o	ршиоп, ае	atri occur	red at the time.	, uate a	riu piace	, and due to	uie cause(s)
Me	29b. Signature and title of centifier						e number					ed (Month,	
	K. Nourt	Lan	Ren all			300	060	0)(0	5	Fel	OVERA	Ry (2	2009
	30. Name and address of person who d	bmpleted cause	of death (Item 23	a) (Tyne	Print)							3	,
	KAQL QUECT-1	H&C25		, (+3 po)	SCY	2 (	ATO	4)(4	AUENI	22	RAI	TIMO	2009 RE 21229
	31. Date filed (Month, Day, Year)		egistrar's Signature		, 00			`		-0	~~	.,	1

State Registrar

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barked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State-of Maryland / Department of Health and Mental Hygiene

NAME KNOWN TO PHYSIEIAN: AMBUSH, WENDELL permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination at once. Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

**Funeral** Director

Be Completed by Funeral Director

ļ

Physician /Medical Examiner

Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Medical Certification: To Be Completed by Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

249 45 46 Division of Vital Records, P.O. Box 68760,

1- For Amend Items 24a, 6, 25, 26 per dr., 888,02/13/09dhb Certificate of Death	Reg. N	711114	04277		
1. Decedent's Name (First, Middle, Last)	2. Date of Death	TYPAA	3. Time of Death		
Wendell Ambush  4a. Facility Name (If not institution, give street and number)  4b. City, Tqwn, or Location of Death  4c. County of Death					
LA MARYLAND HEALTH EARE SYSTEM PERRY POINT		eren	^		
5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 North Days Min. 2 North Days Min. 2	8. Date of Birth (Month, Day, Yea June 30,	r) 9. Birth Cou	place (State or Foreign intry) unk		
10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
MD Cecil Perry Point			1 □Yes 2√√ No		
10e. Street and Number         10f. Zip Code           446 Front Street         21903	10g. C	Citizen of What Cou USA	intry?		
11. Marital Status unk 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: wh			
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	unk 16b.	Kind of Business/Ir	ndustry unk		
Elementary/Secondary (0-12) College (1-4or 5+) unk unk					
17. Father's Name (First, Middle, Last) unk 18. Mother's Name	(First, Middle, Maide	en Surname)	unk		
19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural	l Route Number, City	or Town, State, Zi	p Code)		
VAMC Perry Point Bldg 361 Perry Point,		2			
20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Anther (Specify) in State	ate 20c. l	Location - City or To	own, State		
21. Signature of Funeral Service Licensee Ronard S. Wade Director State Anatomy Board Baltimore, MD 21201		ltimore S	Street		
23a. Parti. Enter the diserie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shorts, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Approximate Interval Between Onset and Death UNENDER OF CONDITION OF					
Due to (or as a consequence of):  ESO PHREEN CARENOMA STREE	TIT				
that ill matter events	DISENSE				
Due to (or as a consequence of):					
IF FEMALE.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliv Month	ery Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown					
	24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of		
25. Was case referred to medical 26. Place of Death	1 □ Yes 2 🔼 N	o 1 □Yes	2 🔼 No		
examiner?	ne 5 Residence	6 ☐ Other (Specia	fy)		
27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28a. Date of Injury 28b. Time of Injury Work?  1 Natural 5 Pending investigation  M 1 Tyes 2 No	8d. Describe how inju	ury occurred			
3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street a City or Town, Star	and Number or Rura te)	al Route Number,		
29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.					
29b. Signature and title of certifier  Melliose A. Sart MD.  29c. License number 15109h-1	29d. D	ate signed (Month,	Day, Year) 7, 2009		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MELELIA B. SANTOS, M.A., VA MALYLAND HEALTH PARE SYSTEM, PERRY POINT, MD 21902					
31. Date filed (Month, Day, Year) FEB 1 3 2009  37. Registrar's Signature  A. January					

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per doc g888 2-13-09 vt State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 4,2009 Marie E. Butler **Physician** 3:10 PM /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner HOSDITA timore DKINS 101 TO If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Nonth, Day, Year) Months Days 1 M 2 220-12-5951 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f shov must be notified at 1 Dyes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? Fecteral 21213 death Completed by Funeral ural", or items ? I Examiner mu Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factoru eam Stress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental tem 27 is marked of anson rannie ၉ 30hnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Baltimore, MD 2 Date 20c. Location - City or Town, State Street 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ŏ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department o Important: If any Injury or Bultimore, MI 2.10.2009 4 Donation 5 Dother (Specify) Mt. Zion 22. Name and Address of Facility Varyon C. Greene Foreral Services
4905 York Ad Baltimore, MD 21212 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sudden /Medical Due to (or as a consequence of): **Examiner** remic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ohysician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending philogophics at the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 📉 No Day Month Year 4☐Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Unknown cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2□No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X ER/Outpatient 1 No 2 No Certification: To 1 Inpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural 2 Accident Injury after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/04/09 ロアマティ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 705 DIGITAL DELGMO FERNANDO 21090 ME CINTINICU M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

09-00953 Paul Blomgren

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 2, 2009 0835 hrs **Medical Examiner** Paul Andrew Blomgren 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Fort Washington Fort Washington Hospital Center 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** Foreign Hours Days 09/03/1957 Country) California Director 1X M 2 F 219-74-0283 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No Oxon Hill Prince George's or 28a-f shov Maryland notified at once. with the Maryland rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. 20745 2040 Alice Avenue Apt 203 ō 23a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11 Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc. White, etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes Specify: White Yes 2X No specify: If Yes, Give Yee Widowed Divorced hours after If iten; 27 is marked other than "natural", her traumatic event, the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. 21215-0036 Office Equipment Field Service Engineer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Mather Donald Stanley Blongren Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 10709 McGregor Drive Columbia, MD 21044 2 Lauren Korenic (Sister) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Clarksville, Maryland Important: I 2-7-2009 Columbia Memorial Park Other Specify Donation 5 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service License 5555 Twin Knolls Road Columbia, MD 21045 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Part I. Enter Physician failure. List only one cause on each line. /Medical Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit 23a,PII,27,permE, g888 2/25/09 TT Physician/Medical X UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 3b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 ✔ Unknown þ Chronic alcoholism Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 4 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 1 ✓ Yes No 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 X Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 February 3, 2009 OCME O.C.M.E. M TR 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year arkar State Registra

			1- State of Maryland / Department of Health Certificate of Deat	th	giene 2009 0428	30
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Patricia T. Barrett	2. Date of De FySyys		
د	Examin Funeral Director		baltimore washington hedical benter	nder 24 Hrs. 8. Date of Bir	th (Y) Year)  4c. County of Death  9. Birthplace (State or For Country)  Mary Land	ele) preign
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		10d. Inside City Li	imits
	a-f shu	ctor	Maryland Anne Arundel Millersville		1 □ Yes 2X	] No
	with the	Director	10e. Street and Number 10f. Zip Code 21108	2	10g. Citizen of What Country? U.S.A.	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hyglene. Department of Heatih and Mental Hyglene important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show stry injury or other traumatic avant, the Medical Exercit arrival to notified at annex.	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic II Yes, specify Cuban, Mexi	Origin? (Specify Yes or No		
036	al', or i	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21☐ No If Yes, Give 1 ☐ Yes 21☐ No Spec Year or Dates:	city:	Specify: White	
Maryland 21215-0036	in 72 ho n "natur legical	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during n	most of working	16b. Kind of Business/Industry	
212	ed with	Com	Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worke		FA Davis	
and	d be file	Be	17. Father's Name (First, Middle, Last)  James J. Duffy, Sr.	Nother's Name (First, Middle Gertrude L	, Maiden Sumame) • Buckingham	
ary	should and Me mark umati	Ţ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nur	umber or Rural Route Numb	er, City or Town, State, Zip Code)	17
Σ,	and 2 lealth a m 27 is		Brenda Barrett / Daughter 310 Poplar Road	Millers Date	Sville, Maryland 2110	08
more	Pages 1 ent of H nt: if ite ry or ot		20a. Method of Disposition  1 XI Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Loudon Park Cemetery	1		
Baltimore,	permit. Departm Importa sny inju		21. Signature of dineral Service Licensee 22. Name and Address of Fa	acility Gonce Fun	eral Service, P.A. timore, Maryland 212	
-			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	h as cardiac or respiratory a	rrest, Approximate Interval Betwee	n
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Superior Masonterior  Due to (or as a consequence of);	arting 1	Drombox)	
	Examiner		per ton his			
	nsit	Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
0,	cate be exectly physicien and the burial-transit	Еха	that initiated events resulting in death) Last  Due to (or as a conse luence of):			
68760,	ficate b physic s the b	edicai	d Lung comicer			
.O. Box (	The law requires that the death certificate thes been signed by the ettending tage 2 should be deteched for use as	d by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
<u>α</u>	w requires that been signed b should be dete		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	-1	tobacco use contribule to the cause of death Yes 2  No 3 Probably 4 Unkr	
Division of Vital Records,		Completed		24a. Was auto perfi 1 \( \triangle Yes		ilabte e ol
Vita	Physician: Th rthis certificete ral director, pag	Be	examiner?	Place of Death   Check only		
0 ر	ig Phys ter this neral di	on: To	1		idence 6 □Other (Specify) how injury occurred	
isior	Attending r death. sctor: Alter by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	281. Location	(Street and Number or Rural Route Number,	
Ö	itei or / urs after rai Dirs	Certi	4   Notificide Building, etc. (Specify)		wn, State)	
2	To the Hospitel or Attanding Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edicai	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date of my knowledge, date of my knowledge, death occurred at the time, date of my knowledge, date occurred at the time, date of my knowledge, date occurred at the time, date of my knowledge, date occurred at the time, date of my know			
	To the within To the compl	M	29b. Signature and title of certifler  DU-80	O 6	29d. Date signed (Month, Day, Year) 0 2 0 7 2 000	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	a) Dr.1	Glas Burnie,	my
	Sta Regist		31. Date liled (Month, Day, Year)  32. Registrar's Signature			

Patricia Barrett

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 1330 EE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 KKF 57 August 214-78-8061 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never worked 0 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph A. Butco Laura Rothrock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Sullivan / Niece 11911 Erwin Ridge Ave., Charlotte, NC 28213 Date 16, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crem. 2009 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01053 313 Talbott Ave., Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Not 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 | Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ■ No 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

iral", or items 23a or 28a-f show

"natural",

of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Medical

of Health a

permit. Pages Department of Important: if it any Injury or o

Director

Funeral

Completed by

Be ပ MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-transit attending p cate has been signated by page 2 should b

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. funeral director. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner Death 28b. Time of 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Medical Certificat 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Reg. No. 2013/09dhb Certificate of Death Reg. No. 2013 1 - For State Registrar 04282 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 10:40 PM February Doris Katie Bowley 7, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. Director Aug. 9, 1927 Maine <u>013-34-1463</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Willrich Circle, Unit C 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chester Luther Drew Mildred Etta Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Willrich Cir., Unit C, Forest Hill, Maryland Donna Bowley / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page:
Department o
Important: If I
any injury or once. Hilltop Service Corp. 2-13-09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign June of Funeral Service Licens 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** se disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dile to (or as a consequence of): physician and the burial-tran Due to (or as a consequence of): Physician/Medical DERMEICATION APPROVED BY MEDITAL IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month. Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 01/22/2009 0130 1 ☐ Yes 2 X No aMSubject fell 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7601 Osler Drive determined 4 Homicide Hospital Towson, MD

Box 68760, within 24 hours a

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

J. D.

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

615 LO. MEDMI Rel

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 04283 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Month **Physician** Τ. Bishop Celeste 3:00PM 10 2009 Februar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Baltimore Square Hospital -ranklin | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | NOV 26, 1992 3 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 218-12-4380 1 ☐ M 2 🔀 F 85 Maryland Director Usual Residence of Decedent 1∩a State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygbert. In Tatural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Maries Exp. Inc. 1 and 10 an 1 ☐ Yes 2 ☑ No Director Md. Baltimore Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1214 Berkwood Road 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. δ Specify: White 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( 12 should be fi h and Mental F 2 Joseph Rybak Theresa Grono 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lorraine Bishop(Daughter) 1214 Berkwood Road Rosedale, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of h 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 2-16-09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature Funeral Service Licensee account Sales 1201 Dundalk Avenue Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. ist only vie cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemorrhage **Physician** Intracrania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the sequentially list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transi and Due to (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical the as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for 1 Month Day Year 5 ☐ Other (specify) □Yes 2 □No P.O. ned by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Prnysi within 24 hours after death. To the Funeral Director: After this r completely filled in by the funeral dir 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After t Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c, Licensoumber 71 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce MA 10, 2000 February

State Registrar

DHMH 17 Rev 1/2001

Bishop

eleste

ORIGINAL

9000 Franklin Square Drive

Baltimore MD, 21337

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

elinger

Stephen

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2009 **Physician** Month Campbell 9-45AM 5 /Medical acility Name (If not institution, give street and number City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign last birthday) **Funeral** Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 res 2 □ No Director MD10e. Street and Number 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S Armed Forces? N Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life\_DO\_NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me opondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1553 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ESOPHAGEAL CANCER WITH METS moneto /Medical Due to (or as a consequence of): Examiner SCHIZOPHREN, A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy φ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death P.O. the been signed by a should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe certificate Division or Vital 1∐ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Maprier of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred → Natural 5 ☐ Pending investigation 1 🗌 Yes 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) replino 20053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 110

Registrar

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GUPTA

32. Registrar's Signature

SHAWNN AC 31. Date filed (Month, Day, Year)

FFB 1 3 2009

SANTIAGO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 04285 Rose Marie Curtain Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 8, 2009 1435 hrs Medical Examiner Rose Marie Curtain

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** Ruxton 2002 Indian Head Road 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) reign North 5. Social Security Number 6. Sex Foreign **Funeral** Days Hours Months August 17,1955 Director 216-68-8261 1 M 2 X F 53 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 Yes 2 X No Nottingham 23a or 28a-f show Balto. Md. with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Court Featherstone 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married 2 X No Yes Specify: American Indian specify: Yes 2 X No Δ Divorced Yes. Give Year after 3 Widowed is marked other than "natural", atic event, the Medical Examiner <u>,</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+ Elementary/Secondary (0-12) 1 and 2 should be filed within 72 Self-Employed 21215-0036 House Cleaner 18.Mother's Name (First, Middle, Maiden Surname) ment of Health and Mental Hygiene 17. Father's Name (First, Middle, Last) Bonnie Locklear Be <u>Iron Mackfee Locklear</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD Featherstone Ct. Nottingham, Md. item 27 Spouse Mark E. Curtain 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition timore, crematory or other place) Removal from State 1 X Burial 2 Cremation 3 Balto. City Pages 1 2-13-2009 0aklawn Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Home 21 Signature of Funeral Service Licensee 21236 9705 Belair Road Nottingham, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death We dical Hypertensive cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and AMENDED 23a,27,perME, g889 3/10/09 TT Physician/Medical X UNPENDED physician a 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Month Day Year 23b. Was decedent pregnant in the Live birth Fetal death for use as past 12 months' Pregnant at time of death Other (Specify) 5 Yes 2 No 9 V Unknown 9 Unknown signed by the a be detached for 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part 1. Part II. Other significant conditions Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? has 2 sl No Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital æ Other, Residence 6 V Other: Scene Hospital: Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 this 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: Yes 2 No 1 X Natural Pending Director: Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) Suicide determined Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 9, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year) State Registrar

Russell Alexander MD.

32. Registrar's Signature ORIGINAL

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February Physician 2009 6:15 A. M Robert Andrew Carrier /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours Days Min. Months 1**™** M 2□ F 82 437 28 5365 11/21/1926 Louisiana Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2K No Montgomery Burtonsville Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3415 Greencastle Road 20866 U.S.A. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates: WW II 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Completed by **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Steel Company 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Marie Paillet မ Sidney Carriere 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine McGruder / Daughter 6498 Malindy Circle Columbia, Maryland 21045 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 02/09/2009 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature un ral Service Lice 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction **Physician** 30 Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Ischemia 2 Hours Sequentially list conditions, for y leading to in mediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Coronary Artery Disease 10 Years and Due to (or as a consequence of): physician a the burial Division or Vital Records, P.O. Box 68760, Vascular Disease 15 Years Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No Hypertension 24a, Was an Jas page 2 performed? certificate I Seizure Disorder 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA P After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural within 24 hours after com...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22966

State Registrar

31. Date filed (Month, Day, Year)

Thomas H. Burguieres, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



7300 Van Dusen Road

**ORIGINAL** 

February 5, 2009

Laurel, Maryland 20707

D

State of Maryland / Department of Health and Mental Hygiene 04287 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOYCE AILEEN CANAPP 2009 6:40P **FEB** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Westminster Dove House 8. Date of Birth (Month, Day, Year) Feb. 17,1947 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M XX F Months Days Hours 213-48-6564 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examples must be notified as 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director Baltimore County 1 ☐ Yes 2 No Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5810 Westwood Avenue 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elias Wilf Customer Service Rep. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic evance. Evelvn Aileen Reinhardt Grammer Owen Franklin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Adams (Daughter) 2706 Ebbvale Rd. Manchester, Md. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 2-16-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licensee ใหรราหาศัยที่อิริยา Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PHEUMONIA - Physician ASPIRATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sclerus sis Multiple Sequentially list conditions Examiner rany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the a detached fo 1 ☐ Yes 2 No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) + 6 \$ \( \text{Plc.} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier pum usitu mo 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIYA 349 Mal wire HESTMINSTER, MI) 21157 malwim DR, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FFR 1 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 9:28 ₩ PHILLIP STANLEY CLARKE 11,2009 Feb /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Pasadena Anne Arundel 7946 East Shore Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (in yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 219-12-8727 1 ■ M 2 □ F 4.1925 Maryland Director 84 Jan. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ar than "natural", or items 23a or 28a-f show Md. 1 ☐Yes 2 No Pasadena Anne Arundel Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 7946 East Shore Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MaYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: δ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Master Electrician Locke Insulator 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and 1 ental H Item 27 is marked oth other traumatic even Be Maude Clarke E11wood Clarke မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June R. Clarke (Wife) 7946 East Shore Road, Pasadena, Md. permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. once. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02 - 13 - 09Crownsville, Md. Crownsville VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 2 3204 Mountain Rd, Pasadena. Maryland 21. Signature of Fun al Service Li art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Immediate Cause (Final **Physician** 54 disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Examiner Physician: The law requires that the death certificate be executed ing physician and as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 🗀 Ectopic pregnancy in the past 12 months? Month Day Year ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fo 1 □Yes 2 □No o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pate has After this certificate funeral director, pag 2 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated.

State

29b. Signature and title

30. Name and address

Registrar DHMH 17 Rev 1/2001 of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Sw Glen Burne MD21061

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PERPUARY Day Year **Physician** 10,552M 2009 Boyd Russell Crotts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARUNISEL AMNE BURNIE BARTIMORE WARHINGTON MEDICAL PHITE 2 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** Days Hours Months 1 XM 2 ☐ F 28, 83 Mar Director 578-20-9658 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Machael Experiment and be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Laurel the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20724 U.S.A. 6 Rose Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 [X]Yes 2 □ No If Yes, Give Year or Dates: 1943-46 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10 Brick Mason Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Corbin Central Crotts Vera Grace Sink ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If Item 27 any injury or other troone. Michael Crotts /son 9515 Haddaway Place, Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gdns. Feb 16, 09 | Marriottsville, MD 22. Name and Address of Facility 21. Signal/re of Funeral Service Cons Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 HUIL M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NASOPHARYNGEALCAREMOMA Physician METAGOATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician at the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending phase to IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier win 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drive Gien Burne My 20161 32. Aegistrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 3:45 Marilyn Dells 2009 February 9. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days Hours Min 1 □ M 2 🖫 F 3, Delaware 64 Mar. 1944 215-42-2051 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examination at the notified at 1 ☐ Yes 2 ☑ No Director Parkville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 United States 1804 Wendover Ave. Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√∑ No Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Success for all Foundation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanore Frances Arthur John Dells ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 2802 Page Court Fallston, Maryland 21047 Amanda Price / Daughter timore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Feb. Date 3 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o Pages Evans Funeral Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Forest Hill, Maryland Bel Air Evans Funeral Chapel & Cremation Service-BelAir
3 Newport Drive Forest Hill, Maryland 21015 21. Signature of Funeral Service Licenses 21 COUR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BRONCHICLITIS OBLITERANS ORGANIZING Physician PNEUMONIA MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HONTH INTERSTITIAL PNEUMONITI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed 2 200 1 ☐Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Menner of Death 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.

le Funeral Director: Aft bletely filled in by the fun 1 ☐Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) and manner stated To the twithin 2 To the F 29d Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier 2009 FEBRUARY 1153430 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 6701 NORTH CHARLES STREET BALTIMORE CHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2:50 PM reder ICK 616 2009 -ev 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Thavs Hours Min. (Month, Day, Year) The Age 1921 enesis ocial Security Number ome DOGG 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 18-03-2060 1 **⊠** M 2 □ F Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Kingsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. A 66 13 ista 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service alemon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dreies Minnie Henry Muller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kingsville, MD 20c. Location - City or Town, State Vista Dreier -Species 6613 Mt Rd 21087 m.idred 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of 216/09 Rosedale, MP Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Parkville Cremation Sarvice -Chapel Evans Funeral Sternain Harford Approximate Interval Between Onset and Death 23a. Part v. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due o (or as a consequence of): Hy Da Days Dehydra han Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Dre week UTI Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? f. 4, 11a how 24a. Was an autopsy performed? Anemia 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Chaturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examine and burial-tran attending physician for use as the buria Physician/Medical ed by the a 2 Completed has certificate director. Be Certification: To this s after death. completely filled in by the 4 Homicide within 24 hours a To the Funeral L Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

Completed

Be ၉

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, Ital Modical Even, inc. must be notified at

permit. Pages 1 and 2 should be filed within 73. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, II". Medic once.

**Physician** 

/Medical

filed within 72 hours after death with

Maryland 21215-0036

altimore,

2 Accident 6 ☐ Could not be 3 Suicide

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number D 3/295

Balhmore

29d. Date signed (Month, Day, Year) 2/12/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5701 Kenwood Ave MD Wende

Klosz 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Degistrar's Signature

State Registrar

H

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)
Stella May Duty 2. Date of Death 3. Time of Death Month **Physician** 2:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salibury Workomica at the L (2 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Country) Virginia Days Hours 1 □ M 2 🖫 F 216-28-1109 76 Director 3-26-1932 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County show of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Dorchester Cambridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 102 Mimosa Drive 21613 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) R&S Elementary/Secondary (0-12) College (1-4or 5+) Refrigeration Vice President 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Glennie Ferguson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patrick M. Duty/Son 2905 Rayshire Road, Baltimore, Maryland, 21230 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages ŏ Department of Important: If It any Injury or of the Otice. 1 Burial 2 Cremation 3 Removal from State 2/12/2009 4 Donation 5 ☐ Other (Specify) Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 21. Signature of Juneral Se vice Line 7250 Washington, Blvd, elkridge, Md21075 238. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year un /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🔁 No 24a. Was an certificate has b irector, page 2 sh autopsy performed? 1 ☐Yes 2 X No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

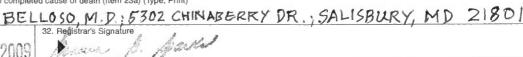
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

GREGORIO M. BE
31. Date filed (Month, Day, Year)

Name and dress of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

02-08-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2009 avis 3 55 PM Febsuan 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balt more Washington Medical Center AnneARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Min. Year) Months Davs 1 3M 2 F Hours 217-56-287 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Nes 2 No **Funeral Director** Anne Surve rundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 788 USA 1106 lall 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 and 2 should be filed within 72 hours after 1 Tyes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No ð Black 3 Widowed 4 Divorced "natural", permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural" any jujury or other traumatic event, the Medical Expone. Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) perator 2 phipping 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be avis nomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 2166 Apt B Glen Burnie, MD -inda Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 17,269 5 ☐ Other (Specify) 4 Depation 21. Signatur Ineral Service Licensee 22. Name and Address of Facility Holys 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumon ammunty ac JUINE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 05+ if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ned by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒ No 24a. Was an autopsy 1 ☐ Yes 2 🗷 No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes n 24 hours efter death. le Funeral Director: A bletely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 02/08/09 64651

State Registrar

31. Date filed (Month, Day, Year)
FEB 13 2009

KHAWAJA-FAROOD

Baltmon Washingto 2. Registrar's Signature General J. Joan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical center, afen Busnie, Anne ARUNDEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 10 9 114294 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 4:49 A M 2009 February Edward Leslie Daugherty Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days Hours Months M 2 F June 11, 1932 West Virginia 214-28-6437 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 TXYes 2 □ No Director Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 309 Idlewild Road 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🎞 No If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Steel Manufacturing Head Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leslie Otto Daugherty Rebecca (nmn) Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Tenly / Daughter 309 Idlewild Road, Bel Air, MD 21014 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 2-16-09 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cardse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 3 robably 1 ☐ Yes 2 ☐ No 4 🔲 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work?

Examiner Jawaherty Edward Leshe-Sr. microso39 Division of Vital Records, P.O. Box 68760,

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit certificate

**Funeral** 

**Director** 

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evaluation and the natified an once.

**Physician** /Medical

Certification: To

1 Natural

2 ☐ Accident

4 Homicide

3 ☐ Suicide

23a\_Certifie

State

Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signat title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) ebruary 12, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2112 Belair Rd. Fallston, MD 21047 vards, m.D.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the To the

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 04295 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY " **Physician** Ĩ0 В DANTZIG 2009 12:50 P<sup>M</sup> MILDRED /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/10/1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K F 95 MD 220-03-4207 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner rust be notified at 1 ☐ Yes 2 No Director BALTIMORE TOWSON MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 7001 NORTH CHARLES STREET 21204 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event than "na once." College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL WORKER AMERICAN RED CROSS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KRIEGER SARAH MONTLACK JOSIAH ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3823 JAY AVENUE, ALEXANDRIA, VA SHARON DANTZIG / DAUGHTER 20a. Method of Disposition Date 20c. Location - City or Town, State ARETHER ON A CHI ZUK (ace) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/12/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) AMUNO CONGREGATION of unemy ervice us nsee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemenna Physician Complications YIRB /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consecuence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 24 hours after death.

e Funeral Director: After this certificate letely filled in by the funeral director, pagr 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WONU Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (101 N. Charley ST TONSON MD 21204 J CHARUES un 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 04296 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** jards /Medical Eacility Name (If not institution, give str 4b. City, Town, or Location of Death reet and number County of Death Examiner Timore If Under 1 Year 7. Age (In yrs. last birthday Date of Birth (Month, Day, **Funeral** Hours Months Days Min. 1 M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Madical Examiner must be notified at annex. 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits Director 1 □Yes 2 □No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 2 □ No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mD21084 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3 Removal from State 4 □ Donation 5 □ Other (Specify)
Signature Funer I Service License torest Hill mo Funeral Chapel-Bel Ar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructure **Physician** Dulmonn dismot disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of) Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 **X**No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSAL 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed 07

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Registrar's Signature 32

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMAN J CHANNES WM 6701 N Chanles ST TOWSIN

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	4 101	ertificate of Death	n n	eg. No. 2009	04297		
	Physicia		Decedent's Name (First, Middle, Last)     MARGARET S. ESHMAN		2. Date of Deat Month FEB.	h Day Year 3	7:15P <sup>M</sup>		
*	/Medic Examin		4a. Facility Name (If not institution, give street and number) GILCHRIST CENTER	4b. City, Town, or Location of Deat		4c. County of Death BALTIMORE	7 . 101		
	Funeral Director		5. Social Security Number 214 - 42 - 9181  6. Sex 1 □ M	Months   Dave   Hours   Min		Year) 9. Birthplace Country) , 1939 Mary1	e (State or Foreign and		
	/land low		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d.	Inside City Limits		
	Ba-f sh	ector	3	herville			1 □ Yes 2XXVo		
	th with the 23a or 2	Funeral Directo	10e. Street and Number 1015 Fallscroft Way	10f. Zip Code 21093	1	0g. Citizen of What Country? USA	,		
036	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be rediffed at	ò	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 No light Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer     □ Yes	Specify Yes or No- to Rican, etc.)	14. Race - American I Black, White, etc. Specify: White			
21212-0036	d within 72 h giene. er than "natu i the Medical	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation five kind of work done during most of wo e. DO NOT use retired) nemaking	rking	16b. Kind of Business/Indust Homemaking ←0			
yland		To Be (	17. Father's Name (First, Middle, Last)  George Frederick Scheeler		ame (First, Middle, Maiden Surname) Marie Schmidt				
Mary	nd 2 shoul Ith and M 27 is mar	-	19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address <i>(Street and Number or R</i> .5 Fallscroft Way l	ural Route Number, City or Town, State, Zip Code) Utherville, Md. 21093				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone.		20a. Method of Disposition  X M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	sposition (Name of crematory or other place) Paul's Cem. 2-2	Date 21 <b>-</b> 09	20c. Location - City or Town, Chesterstown			
Balt	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lassann Funeral H 7401 Belair Rd. B	ome altimore,	Md.			
	Physician	67 7	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		c or respiratory arr	est, Ap	proximate erval Between aset and Death		
	/Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		9.			
	ted sit	Examiner	Sequentially list conditions, and the conditions of the cause. Enter Underlying Cause (Disease or injury						
68/60,	rtificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):						
O. Box 58	ne death certificat the attending phy hed for use as the	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day	y Year				
7.	requires that the neen signed by the	Ď	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		bacco use contribute to the c			
al Kecords,	The law ate has b page 2 sl	Completed			24a. Was a autops perform	prior to complemed?	etion of cause of		
VITAI	Physician: r this certific ral director, I	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othor	ath (Check only on	ence 6 Other (Specify)	1/22220		
	ding Phy th: After thi funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)  1 Natural 1 Pending (Month, Day, Year)	e of 28c. Injury at		ow injury occurred	(o-ja-a		
DIVISION	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.	Certification:	3   Suicide 6   Could not be 4   Homicide determined   28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Si City or Town	treet and Number or Rural Ro n, State)	oute Number,		
	he Hospit n 24 hour he Funera pletely fille	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/c and manner stated.						
	To t To t	Σ	29b. Signature and title of certifier  Athylling hilly us	29c. License number  25 20 5		9d. Date signed (Month, Day			
	15 V		30. Name and address of person who completed cause of death (Item 23a) (Ty	N. Chordes ST.	Balt	6. and 200	201		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Keel					
DHI	MH 17 Rev 1/2	001	FEB 1 9 2009 / 2009		-				

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01195 State of Maryland / Department of Health and Mental Hygiene Diane Eckholdt Certificate of Death 1- For State Rea. No Registrar 2. Date of Death 1 Decedent's Name (First, Middle,Last) Month Day February 9, 2009 Physician/ 2330 hrs Diane Eckholdt Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore County Dulaney Valley Road and Stone Hill Court Towson 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Country) MD **Funeral** Min 2/3/1940 Hours 69 Months Days 218-36-6849 Director 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 X No Glen Arm Baltimore MD s 23a or 28a-f show e notified at once. the Maryland 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number U.S.A. 21057 4303 Manorwood Dr. 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No. imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with t nont of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married Married Specify: White Yes or. 2 X No specify: Yes If Yes. Give Year 3 X Widowed event, the Medical Examiner "natural", 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker marked other than 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Saint John James Walz Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 214 Šaint Johns Pl #5, Brooklyn, NY 11217 Haftan Eckholdt/Son iten 27 is 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) timore, rtant: If it or other 1 X Burial 2 Cremation 3 Removal from State 2/14/2009 Long Green, MD Wilson UM Cem Μt rtment c Other Specify 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A permit meral Service Licensee Green Pastures Dr. Towson, MD. Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line. Death /Medical a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED ysician burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE phy: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth signed by the attending be detached for use as t past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 🗸 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available Completed 24a Was an After this certificate has been a funeral director, page 2 should prior to completion of cause of autopsy death? performed? 1 1 ✓ Yes 2 Yes 26.Place of Death (Check only one) 25. Was case referred to medica Be Other<sub>4</sub> Residence 6 🗸 Other: Scene Hospital: Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Driver auto collision Feb 9, 2009 2320 hrs Certification Yes 2 V No Natural Pending within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Dulaney Valley Road and Stone Hill Court, Towson, MD Could not be 3 Suicide determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 10, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Month, Day

DHMH 17 Rev 1/2001 OCME 2006

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00 PM Feb 2009 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Care Baltimore Essex Riverview If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV • 25 , 1913 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1**X** M 2□ F 95 Missouri 455-18-4479 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the "Molical Evan in or must be notified at 1 ☐ Yes 21 No Director Maryland Baltimore County Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21221 2204 Riverview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 ☐ No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1933-38 1 ☐ Yes 2 No Specify White Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Aircraft Repairs Aircraft Mechanic s 1 and 2 should be filed wind Hygier of Health and Mental Hygier Item 27 is marked other the other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clessie Bell Simpson John Franklin Finney ၉ 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essex, Maryland 21221 2204 Riverview Road Patricia J. (nee Lichti) Finney : If item 27 or other t Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel Date Pages 1 Feb 12, permit. Page Department o Important: If i any Injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear, failure. Ust only one cause of each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIRATION Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uneque or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed e men tra burial-trar Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending ph 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Lirector A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D006 1907 304 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Bultimore MD 21221 1124 Mace hukwuma 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EMPRUARY Day 1, 2009 6:51P **Physician** es /Medical 4b. City, Town, or Location of Death 4c. County of Death imore Facility Name (If not institution, give street and number) Examiner Center Joseph Medical Saint 4 - 185 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 12 F Min. Days Hours **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or than "natural", or items 23a or 28a-f show 1 Yes 2 No Director Street and Number 10f. Zip 10g. Citizen of What Country? di Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 Is marked other than any Injury or other traumatic event, Inc. M. College (1-4or 5+) Elementary/Secondary (0-12) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Noute Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other) City or Town, State 20a. Method of Disposition Date 20c. . Location -1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2116109 4 ☐ Donation 5 ☐ Other (Specify) Chapel-Parkville 21. Signature of Funeral Service Licenses 8800 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): HOURS Examiner FAILURE CONGESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 0063974 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MARYLAND 21204 DRIVE 1601 031 SIDDICI 32. Registrar's Signature State Registrar arka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician William Ronald Fuller 325 102009 /Medical 4c. County of Death N/A 4b City Town, or Location of Death 4a. Facility Name. (If not institution, give street and number) Examiner MOKE If Under 24 Hrs. 8. Date of Birth (Month, Day, 1ay 13, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Numbe <sup>Year)</sup> 1953 **Funeral** Days Hours 214-62-6068 1 M 2 □ F Months Maryland May Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, I's. Medical Examiner must be notified at 1√Yes 2 No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 801 Belvedere Avenue Apt. 3800 W. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Black Specify: 1 ☐ Yes ♣☐ No If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within 72 I of Health and Mental Hygiene. Item 27 is marked other than "nat other traumatic event, I'm Medica Elementary/Secondary (0-12) College (1-4or 5+) Private industry Dental Assistant 12th grade 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Grady 17. Father's Name (First, Middle, Last) Be Henry Fuller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4610 Pimlico Road Baltimoee, Maryland 21215 Patricia Johnson/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 tment of I 20a, Method of Disposition Department of Important: If It any injury or o Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removal from State Lansdowne, Maryland Zion Cemetery 2/16/09 Mt. 21. Signature of Fundral Service Ucensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Baltimore, Md 21215 Approximate Interval Between Onset and Death . Part 1. E , er the disease, or shoc or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final dease or condition resulting in death) **Physician** sboble /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine signed by the attending physician and be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Onknown speen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No of Vital spital or Attending Physician: The hours after death.

uneral Director: After this certificate by filled in by the funeral director, par 1 ☐Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 45100

State Registrar

5601

32. Bagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eso 31. Date filed (Month, Day, Year) 10, 200

Roven Boulevard 212

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AMEND TIEMS amend items 29d per doc, 19a, per fh 31 per dvr

State of Maryland / Department of Health and Wental Hygiene 2888 2 13-09, vt 0 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician JAMES** FRENKIL **FEBRUARY** 2:40 P 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7205 PARK HEIGHTS AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 09/16/1912 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 215-30-7837 96 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene, tem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be ruillised at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7205 PARK HEIGHTS AVENUE 21208 Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status rmed Forces? Mayes 2 ☐ No XYes 2 Yes, Give 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ģ lf Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PHYSICIAN MEDICAL 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ISAAC FRENKIL 2 JENNIE GOLDSCHNEIDER 19a. Informant's Name/Parting (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN FENK WIFE 7205 PARK HEIGHTS AVENUE, BALTIMORE, MD item 27 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other n Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any Injury or otl 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 02/09/2009 REISTERSTOWN, MD 4 Donation 5 ☐ Other (Specify) of Funeral Serfice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the dise se, ir com shock, or heart failure. List only complexitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RENAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RESPIRATOR Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 □ Yes 2 □ No. 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 🗆 No 2-No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → No After this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 11 Natural 5 Pending investigation s after dec. eral Director: A' v filled in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a LC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5780A00 GLAGSA 2700 DA QJA 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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amend items 10d, 17 per fth 8888 2-13-09
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year FEBRUARY OF 2009 6:50 A **Physician** 90RDON MICHAEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER N/AIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/16/1976 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 XM 2 ☐ F 32 NY Director 077-60-5356 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Md Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 21222 413 Maple Lane Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 212 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Abacus Security Guard Security 12th 17. Father's Name (First, Middle, Last)
Clayton Gordon 18. Mother's Name (First, Middle, Maiden Surname) Be Joan B. Wiggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 1010 W. Baltimore St. apt 203 Balto. Md 19a. Informant's Name/Relationship (Type. Print) Joan B. Wiggins/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Mt. Carmel Cemetery 2/14/09 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Md 21206 Chatman-Harris F.H 4210 Belair Rd. Balto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS 7 DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERITONITIS 7 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. the 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an autopsy performed? 2 No 1 Yes e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Rangachae FEBRUARY DLG 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANGACHARIM.D. 4940 EASTERN AVENUE BALTIMORE, M.D. 21224 31. Date filed (Month, Day, 32. Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma	aryland	Depa <i>Cei</i>	artme <i>rtifice</i>	nt of He ate of D	ealth and l eath	Menta	Hygiei Reg.	ne2009	04304	
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	Physici /Medio		Jacquelyn Jewe	l Gair						Febr		Day Year 2009	1215 P M	
· ·	Examin	er	4a. Facility Name (If not institution, giv	e street and number)					ocation of Death	1		4c. County of Dea		
- ALVEN			Holy Cross Hospital  5. Social Security Number 6. S	ov 7 Age	(In ure la	ıst birthday)		lver Spr erlYear	'i ng f Under 24 Hrs.	Montgomery  A Hrs. La Date of Birth				
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	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits	
	Maryl -f sho	ţō	Maryland Howard		Colu	ımb <b>i</b> a						1 □ Yes 2X N		
	r 28a	Director	10e. Street and Number		0010	amb r d	10f. Z	Zip Code			10g.	Citizen of What Co	ountry?	
	th wit		10209 MacGill Avenue					21044				USA		
	tems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 📉 N	er in U.S	i. 13. V	Was Dec	edent of Hisp ecify Cuban,	anic Origin? (S Mexican, Puert	pecify Yes o Rican, et	or No-	14. Race - Am Black, Whit	erican Indian, e. etc.	
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene. When than "natural", or items 23a or 28a-f show ent, the Medical Exeminer must be notified at ent.	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 1 N If Yes, Give Year or Dates:	lo	1	I∐Yes	2 <b>/</b> No	Specify:			Specify:	White	
21215-0036	2 hour	ted	15. Decedent's Ed (Specify only highest gra			16a. Deced	dent's Us	sual Occupation	on		16b.	Kind of Business		
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21	ed wit ygien ser th t, the	Cou		3		Teach	ner					Private Sc	hool	
and	be file	Be	17. Father's Name (First, Middle, Last)					18	3. Mother's Nam			len Surname)		
Ĕ	hould nd Me: marke matic	丘	Henry H. Taylor, Sr. 19a. Informant's Name/Relationship (			10b Mailin	a Addro	on (Stroot on		Gibs		y or Town, State,	Zin Code)	
Baltimore, Maryland	nd 2 salth ar 27 is rtrau		Janet Bouland- daughte				-		Laurel, N				2 <i>ιρ 000θ)</i>	
Je,	as 1 a of Hei		20a. Method of Disposition		20b. Pla	ace of Dispos metery, cren	sition (N	ame of		Date		Location - City or	Town, State	
<u>Ĕ</u>	Page ment ant: If ury o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				-		ery 2/12,	/2009	Ade	lphi, Mary	land	
3alt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmoortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen			22 F1e	Name	and Address	of Facility Iome , INC.					
	⊕			01234		760	)1 Sa	ndy Spri	ng Rd., l	aurel		and 20707		
			23a. Part 1. Enter the disease, or compands shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	e.			ode of dying,	such as cardiac	or respira	tory arrest,		Approximate Interval Between Onset and Death	
	hysician /Medical		disease or condition resulting in death)	Due to (or as a			rest							
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587	phys s the	edical		.d										
		Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of de	livery	
O. Box	it the death certified by the attending tached for use as	sicia	in the past 12 months? 1 ☐ Yes 2 <b>XX</b> No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Other (	pregnancy specify)			_	Month	Day Year	
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Š,	The law requires that the death certained has been signed by the attendin bage 2 should be detached for use a	چ ا	Part II. Other significant conditions of Urinary Tract Infecti	ŭ		0	iderlying	cause given i	in Part I.	23e.			the cause of death?	
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He He	sician: The law certificate has b irector, page 2 s	Completed	Ventricular Tachycard	iia, Pacemake	r					24a.	Was an autopsy performed?	prior to	utopsy findings available completion of cause of	
			25. Was case referred to medical					0.0	6. Place of Dea	,	Yes 2 1		2 □ No	
5	<u>&gt; .∞ o  </u>	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 🗆 E	:R/Outpatien	t 3 🗆 [	045				6 ☐Other (Spe	ecify)	
0	h. h. After the funeral	i.i	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury		28c. Injury at Work?				jury occurred	0.1)	
Sio	tenul leath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				М	1 □Yes	s 2□No					
	after d Direct in by	Certification: To	4 Homicide determined	28e. Place of Inju building, etc	ry - At hom . <i>(Specify)</i>	ne, farm, stre	et, facto	ry, office			tion (Street or Town, Sta		ural Route Number,	
	ours a		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my know	ledge, death	occurre	d at the time	date and place	and due	to the cause	e(s) and manner a	s stated	
3	within 24 hours after death.  To the Funeral Director. A completely filled in by the fu	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination	on and/or inv	estigation	on, in my opin	ion, death occu	rred at the	time, date a	and place, and due	e to the cause(s)	
F	To the comp	Ĭ	29b. Signature and title of certifier	-			2	9c. License n	umber		29d. [	Date signed (Mont	h, Day, Year)	
	7		1 State	- mo				D68	096		Fe	bruary 9,	2009	
	1		30. Name and address of person who		,		,							
	Sta	20	Satyam Shah, MD, 15 31. Date filed (Month, Day, Year)	32. Registra					20910					
	Sta Registra		FFR13	2009		ire /	W GAR	No. of Street, or other Parket.						

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			For State Registrar	State of Ma	aryland /	-	artment of I rtificate of		Mental Hy	giene 2 (	009	04305
ı	Physici /Medio		1. Decedent's Name (First, Middle, La	st) Michael S	. Georg	giou			Day	Year 2009	3. Time of Death 9:30 A. M	
	Examir		4a. Facility Name (If not institution, given 11 Church Streets)  5. Social Security Number 6.5	eet 7. Ag	e (In yrs. last	birthday)	Balt If Under 1 Year		th	4c. County	of Death	nde1 ace (State or Foreign
	Director		213 28 1438  Usual Residence of Decedent  10a. State 10b. County	I□M 2□F	86	Yrs.	Months Days	Hours Min	(Month, De 03/25/	1922	Gree	Dd. Inside City Limits
	the Maryla 28a-f sho	rector		Arundel		1tim			ı	10g. Citizen of		1 ☐ Yes 2🏋 No
	death with	Funeral Director	11 Church Stree	12. Was Decedent	Ever in U.S.	13.		1225 Hispanic Origin? (	Specify Yes or No	U.S		
9800	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Exempre must be redified at	þ	1 Never Married 2 Married 3 Widowed 4 🗷 Divorced	Armed Forces? 1	No		If Yes, specify Cub 1 ☐ Yes 2 X No		to Rican, etc.)	Bla Specil	ck, White, e	
1215-	within 72 h ene. than "natu	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12) 8th	ducation a de completed) College (1-4or 5		(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	orking	16b. Kind of B		ustry Cleaners
land 2	ild be filed fental Hygi rked other tic event, i	To Be Co	17. Father's Name (First, Middle, Last	Simeon Ge	orgiou			18. Mother's Na	me (First, Middle ene Papa	, <i>Maiden Surn</i> ar	ne)	orealier 5
Baltimore, Maryland 21215-0036	and 2 shouealth and N n 27 is mai		19a. Informant's Name/Relationship	1		7925	ng Address (Street Andorick	Drive	_	ver, City or Town		,
timore	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)		Lawn	osition (Name of matory or other plan Cemetery	02/	Date 16/2009	20c. Location Baltim		wn, State Maryland
Bal	permi Depar Impor any Ir	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Gonce Funeral Service  4001 Ritchie Highway Baltimore, Mar  23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Cerebrovas cular Accident										
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as	a consequend	ce of):	cular	Accid	lent			M·Nulla
68760, 2	icate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequenc	ce of):						
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total states.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea	ath 3[	☐ Ectopic pregnand ☐ Other (specify) _	ey			ate of delive	ry Day Year
ords, F	equires that sen signed I ould be det	þ	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the u	nderlying cause giv	ven in Part I.	23e. Did 1	. /		e cause of death?
of Vital Records,	n: The law r ficate has bo rr, page 2 sh	Completed	OF Was soon of made and live						1 ☐ Yes	psy ormed? 2000No	prior to con death?	osy findings available inpletion of cause of 2 No
on of Vit	ding Physicla th. After this cert funeral directe	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	ent 2  ER/ ry 28t y, Year)	Outpatier  b. Time o	f 28c. Inju Wor	er: 4 🗆 Nursing	Home 5 Resi			)
Division	ital or Atter rs after dea al Director led in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	e 290 Place of Ini	ury - At home, c. (Specify)	farm, str	reet, factory, office		28f. Location ( City or To	Street and Numi wn, State)	per or Rura	Route Number,
	the Hospi thin 24 hou the Funer mpletely fill	Medical	29a. Certifier (Check only one)  Certifying P 2 Medical Exa	nysician: To the best miner: On the basis o and manner sta	of my knowled f examination ated.	dge, deat and/or ir	h occurred at the ti nvestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and m	anner as st and due to	ated. the cause(s)
		_	29b. Signature and title of certifier  30. Name and address of person who  Per (E Paul 9)  31. Date filed (Month, Day, Year)	Padget	ms		29c. Licens	03329	6	Z I	2 09	Day, Year)
	Sta	te.	30. Name and address of person who Neil E Padgi 31. Date filed (Month, Day, Year)	H MD 7	eatn (Item 23 77// - ( ar's Signature	a) (Type,	Tenfiel	d Rd.	Glew B	urnie,	MD.	21061
	Registi		FEB 1 3 200	9 de ma	A.	Jan	Mal	· · · <u> </u>				

09-01184
Renee L Glanding

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of Death	Reg. No	. 2009 0430
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day February 9, 20	009
	4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital	4b. City, Town, or Location Baltimore		4c.County of Death Baltimore City
Funeral Director	5. Social Security Number 6. Sex 7. Age 219 84 3433 1 M XX F 46		nder 24Hrs. 8. Date of Birth(MN ours Min. Sept. 13	WDD/YYYY) 9. Birthplace (State or Foreign Country) MD.
Maryland. 28a-f show any datonce.	Usual Residence of Decedent  10a. State	10c. City, Town or Location Baltimore County		10d. Inside City Limits  1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.		10f. Zip Code 21234		JSA
or items must be a	Widowed 4 A Divorced if Yes, Give Year or Dates:	If Yes, specify Cuban, Mexic  1 Yes 2XX No specific Cuban, Mexic	can, Puerto Rican, etc.) . cify:	14. Race - American Indian, Black, White, etc.  Specify: White
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner To Be Commileted by		5+) during most of working life. DO N Disabled	OT use retired)	. Kind of Business/Industry  Disabled
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	William R. Lein		ther's Name (First, Middle, Maide Ina N. Mann	
- 얼음 얼음	19a. Informant's Name/Relationship (Type, Print)  Edna N. Lein (Mother)  20a. Method of Disposition	8609 Trumps Mil	l Rd. Baltimore	
Baltimore, permit: Pages 1 ar Department of Hee Important: If ite	1 Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify: 21. Ignature of Funeral Service License	Metro Crematory Inc.		altimore, Md.
Balt Bernit Depart Import	23a. Pal I. Enter the disease, or complications that caused		Rd. Baltimore,	shock, or heart Approximate Interval
/Medical kaminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a const	intoxication equence of):		Between Onset and Death
ted Institution	Sequentially list conditions, if any, leading to immediate cause. Effect Und flying Couse (Disease or injury that initiated events resulting in death). Last			
execui an and al - tra		a,27,28a-f, per ME, g88	38 2/23/09 TT	
. Box 68760, the death certificate be to the attending physicis ched for use as the burish physician/Madi				23d. Date of delivery Month Day Year
P.O. Es that the canada by the detached		h but not resulting in the underlying cause given in		co use contribute to the cause of death?  No 3 Probably 4 Vunknown
Records The law requirate has been page 2 should			24a. Was an autopsy performed 1 ✓ Yes 2	
Vital Rechysician: The this certificate al director, page	25. Was case referred to medical examiner?	26.Place of De ent 2 ✓ ER/Outpatient 3 DOA Other	eath (Check only one)  4 Nursing Home 5 Resi	idence 6 Other:
ion of lending Pheath.  the funeral	27 Manner of Death 28a Date of Inju	1 1 Vec 2		injury occurred
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	3 Suicide 6 X Could not be determined (Specify)	njury - At home, farm, street, factory, office building found: residence	or Town, State) Parkville	
Fo the Ho within 24 P To the Fu completely	2 2 A Certifier (Cheek only one) 2 Medical Examiner: On the basis of examiner and manner stated.	ny knowledge, death occurred at the time, date and amination and/or investigation, in my opinion, death .	d place, and due to the cause(s) h occurred at the time, date and	and manner as stated. place, and due to the cause(s)
	29b. Signature and title of certifier	29c. License num O.C.M.E.		d. Date signed (Month, Day, Year) ebruary 10, 2009
5	30. Name and address of person who completed cause of c Ling Li, MD Assistant Medical Examine	er 111 Penn Street, Baltimore, MD 2	21201	
Stat	e 31. Date filed (Month, Day, Year) 32. Registra	ar's Signature		

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 04307 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Martha Schmidt Gilbert February 7:04p 10 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours Min. 1 □ M 2 🙀 F 219-12-1403 85 June 6 1923 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Carroll Westminster 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 Deer Park Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify. Specify: white 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Carroll Co. Public College (1-4or 5+) Elementary/Secondary (0-12) Secretary Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Edward Schmidt Viola Holman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald Gilbert (son) 3001 Bird View Rd., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
Deer Park Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-14-09 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses Pargrafaig P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, in each line. Approximate Interval Between Onset and Death Immediate Cause (Final ronic Years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

permit. Peges 1 and 2 should be file.
Depertment of Health and Mental: Important; If item 27 is many Injury or other **Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

**Funeral** 

Director

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evanther rust be notified at

2 should be filed within 72 hours after death v n and Mental Hygiene. Is marked other than "natural", or Items 23s

Baltimore, Maryland 21215-0036

Examine Physician/Medical

physician end s the burial-transit use as attending for use as signed by the a Completed by cate has page 2 s certificate Be ۵ After this funeral Certification:

The law requires that the death certificate be executed

Physician:

To the Hospital or Attending

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the f

Medical

State Registrar

P.O. Box 68760,

of Vital Records,

Division

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗹 No 9 HInknown

autopsy performed2 1 □ Yes 2 □ No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Dove 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? House 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

9b. Sigr	nature and title of cert	tifier		
	Will	Uh	MO	

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address ρf person who completed cause of death (Item 23a) (Type, Print)

Kus Stone

filed (Month, Day, Year) FEB 1 3 2009

Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral C

completely filled

> State Registrar

0

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

SAUNDERS 6569 N. CHARITES STHYOI BARMORE UND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aunden

MID



29c. License number

328133

29d. Date signed (Month, Day, Year)

amend #19a Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:17 AM Rosa Lee Hampton 2009 February 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs.

Adopths Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In ye 8. Date of Birth (Month, Day, Year)
11 22 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ▼ F Yrs. 75 Director 212-34-5092 Usual Residence of Decedent 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 Yes 2 No Baltimore Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or 'Examiner must be r Funeral death v 4012 Hayward Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ XNo
If Yes, Give
Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married Married r than "natural", or i Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Ukn College (1-4or 5+) Cleaners Presser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be is marked c Jeff Dolby Rosa Chambers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herman Hamton-Husband item 27 is other tra 4012 Hayward Ave, Baltimore, Md Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any injury or conce. 2/14/2009 Baltimore, Md Cathedral 21 Signature of Fymeral Service License 22. Name and Address of Facility
March F/H West 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Immediat Cause (Final disease or condition resulting in death) **Physician** Ventricular Fibrillation /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Estat Urbary, or Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending for use as use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a O 9 Unknown 9 Unknown Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Hypertension certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes Mellitus 24a. Was an autopsy End- Stage Renal Discase 1∐ Yes 2 X No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No ို After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ai or Attending P Certification; Injury To the Hospital Committee after death.

To the Funeral Director: After a funeral Director After Committee and the funeral Director After Committee and the funeral Director After Committee and the funeral Director After Committee and Committ 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D59062 February 10, 2009 - M.A. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chad J. Hansen, M.A. 2401 W Belvedere Baltimore MA 21215 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Sarkand

)947 Lawrence Hed	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene						
	1- For State Certificate of Death Reg. No. 2	109 0431					
Physician/ ical Examiner		3. Time of Death 0655 hrs					
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of D  3209 Glendale Avenue	eath.					
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9						
Director	215-54-2068 1x M 2 F 45 Yrs. Months Days Hours Min. 10/9/1963	oreign Country) Md					
<b>k</b>	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits					
OW ANY	N. 7	1 Yes 2 No					
the Maryland t or 28a-f show iffed at once	Md Baltimore 106. Street and Number 106. Zip Code 109. Citizen of What						
with the Maryland ns 23a or 28a-f sho be notified at once eral Director		A					
	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A White, e	merican Indian, Black, tc.					
er death , or ite r must Fun	1 Yes 2 X No Specify: W	hite					
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uld be filed within 72 hou Mental Hygiene. marked other than "nat ic event, the Medical Exa TO Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  Electrician Self-E	mployed					
led within 72 hour Hygiene. other than "natuth Nedical Exal	12th ETECTICIAN SELICIES  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)						
be filed ntal Hy rked of ent, th							
5 6 6 0	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street Number, City or Town, Street Number, City or Town, Street Number, City or Town, Street Numb						
2 ÷ 2 =	Gloria Heddinger/mother 3209 Glendale Ave. Baltimore, M  20a. Method of Disposition    20b. Place of Disposition (Name of cemetery,   Date   20c. Location - Ci						
permit. Pages I and Department of Heal Important: If iten injury or other tra	22 Cremation 3 Removal from State Crematory or other place) Greenmount Cem. 2/9/2009 Balto.						
nit. Pa artmen ortant ry or o	4 Donation 5 Other Specify:						
Dep.	hatman-Harris F.H 4210 Belai	ř Rd. Balt.					
hysician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and					
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease  Due to (or as a consequence of):	Death					
	Sequentially list conditions,  b.						
iner	if any, leading to immediate Due to (or as a consequence of):						
led Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
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ficate be a physicia the buria		23d. Date of delivery					
the death certificate be by the attending physici ched for use as the buri Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month	Month Day Year					
e atten for us	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown						
ned by the detached							
ires that signed d be deta	Chronic alcoholism 1_Yes 2_No 3_	Probably 4 Unknown					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buritedical Certification: To Be Completed by Physician/Med	24a. Was an 24b. We authorized? performed? dec	re autopsy findings available or to completion of cause of oth?					
ian: The law requires tha certificate has been signed ector, page 2 should be det Be Completed by	1 ✓ Yes 2 No 1	Yes 2 No					
ician: s certif rector, Be	o 25. Was case referred to medical 25. Place of Death (Check only only)  (Check only only)  (Check only only)  (Check only only)  (Check only only)	Other: Scene					
After this funeral di	O 1 ✓ Yes 2 No 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred						
tendin leath. for: At the fur	1 X Natural 5 Pending 1 Yes 2 No						
ital or Attending are after death. Ital Director: After Ited in by the fune	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)	or Rural Route Number, City					
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the edical Certification	O 29a Certifier	ctated					
To the Hos within 24 h To the Fur completely	(Check only one)  (Check only	to the cause(s)					
To To		(Month, Day, Year)					
O.C.M.E. February 2, 2009							
	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
✓ State	The state of the s						
State Registrar	to the state of th						
H 17 Rev 1/2001	01 OCME ORIGINAL						

09-00947

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HARRIS Physician ROOSEVELT Year FEBRUARY 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. Sounty of Death 4b. City, Town, or Location of Death Examiner RANDALISTOWN NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) TTA **Funeral** Days Months 1 M 2 □ F 224-22-1056 Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 28a-f show 10d. Inside City Limits notified at Funeral Director MD Baltimore Reisterstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 3 any lojury or other traumatic event, the Medical Examinant han 20nee. 711 Cockeys Mill Road 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Types 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖔 No Specify African - American Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Steel Mill Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Harris Lizzie Gregory ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9954 Linden Hill Road Ovings Mills, MD 21117 Gracie E. Scott / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) King Memorial Park 2/15/2009 Woodlawn, Maryland 22. Name and Address of Facility Wylie Funeral Home P.A. of Baito. Co. 9200 Liberty Road Rarbalistown, Maryland 21133 Sign to re of Funeral Service Licensee Rad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a nonsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of). Box 68760, Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by has been sign 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy 1 □ Yes 2 124 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or August. within 24 hours after death. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29c. License number 037333 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALTO. MO 21133 NHC.

32. Registrar's Signature

PEBRYARY 10, 2009

09-01239 Kelly Hopkins

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

04312 2000

Division of Vital Records, P.O. Box 68760, spiral or Attending Physician: The law requires that the death certificate be executed hours after death.  Baltimore, MD 21215-0036  Baltimore, Manually be filed within 72 hours after death with the Maryland and Parkland Andrea Baltimore, MD 21215-0036  Baltimore, Manually be filed within 72 hours after death and Namial Hydere.  Baltimore, Manually be filed within 72 hours after death and Namial Hydere.  Baltimore, Manually be filed within 72 hours after death and Namial Hydere.  Baltimore, Manually be filed within 72 hours after death and Namial Hydere.  Baltimore, Manually be filed within 72 hours after death and Namial Hydere.  Baltimore, Manually be filed within 72 hours after death and Namial Hydere.  Baltimore, Manually be filed within 72 hours after death and Namial Hydere.  Baltimore, Manually be filed within 72 hours after death and Namial Hydere.  Baltimore, Manually be filed within 72 hours after death and Namial	1- For State Registrar	Certific	ate of Death		Reg. No.	200	2 0421			
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≥ 29b. S 30. Na Ri	29b. Signature and title of certifier  30. Name and address of person who Russell Alexander MD.  31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) Assistant Medical Examiner 32. Pegistrar's Signature	29c. License r O.C.M.	E.	29d, Dat Februa	e signed <i>(Mon</i>	th, Day, Year)			

Registrar

Dereva B. Jako

	•	For State Registrar	State of Ma	arylallu / i	_	rtment of F tificate of I		_	Reg. N	2003	04314
Physicia		1. Decedent's Name (First, Middle, Last) William C. Imhof	F					2. Date of De Month Februar	D	ay Year 7,2009	3. Time of Death 1:38P M
/Medic Examin		4a. Facility Name (If not institution, give str				4b. City, Town, or	Location of Dea			c. County of Death	
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Funeral Director		5. Social Security Number 6. Sex 1 🗓 1	M 2∏ F	e (In yrs. last bii	rthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		ay, Year	r)   Cou	place (State or Foreign intry) to.Md.
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina		of examination a							
To th Within To th comp	Me	29b. Signature and file of certifier.			)	29c. Licens	se number		29d. D	Date signed (Month,	, Day, Year)
6		Magn		KA	1	De	2006	1	0	2/09/0	27
*		30. Name and address of person who con		,						1	
		Francis L. Wiegm. 31. Date filed (Month, Day, Year)		1205 Y	ork	Road Sui	te 11 L	uthervil	Le,M	ld. 21093	
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DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

A form

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Leon Jefferson Jr January 2009 8:00 PM 28, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2008 Robb Street N/A Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4-8-1952 Min. Hours 1 X M 2 □ F Months Days MD 212-60-4813 56 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XYes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 2008 Robb Street 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐Yes 2 No Black Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hedwin Company 12th grade N/A Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Clark Leon Jefferson, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2008 Robb Street Balto, MD 21218 Denise Lowery-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 2-10-2009 Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H adus MD 21202 1101 E. North Avenue Balto, ware 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive Heart month Due to (or as a onsequence of) month Bleedina Gastroin testinal Sequentially list conditions, if any, leading to infiniteliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus type 11. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown uncontrolled 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 \( \text{Ye} \) \( 2 \) \( \text{No} \)

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

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MD

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the W-dical Expriner, must be notified as once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Examiner burial-trai attending physician for use as the buria Physician/Medical ned by the at detached fo s been signed by t should be detach þ Completed cate has t this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

23b. Was decedent pregnant in the past 12 months? I∐Yes 2.2KNo 9 Unknown

26. Place of Death (Check only one)

1 ☐ Yes 2 XNo

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0052316 29d. Date signed (Month, Day, Year)

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3333 N. Calvert MD St., Baltimore MO THERESA 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registrar's Signature

within 24 hours a

the

			For State Registrar	State of Mai	yland		tificate o			F	Reg. No. 2	009	04316
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Charlotte Sheen							2. Date of Dea Month Februar		2009	3. Time of Death 11:25 A <sup>M</sup>
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	Funeral Director			]м 2∭Х Г	91	Yrs.	Months Day	s Hours	Min.	8. Date of Birth (Month, Day Apr. 1	.3, <sup>Year)</sup> 191	L7 Vi	place (State or Foreign htry) rginia
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	th with	Funeral Director	8800 Walther Blvd.	, Apt. 31	80		2123	34			USA		
	r deat	nue	TT: Marica Otatao	12. Was Decedent Ev Armed Forces?		13. \	Nas Decedent of Yes, specify Cu	f Hispanic Or ıban, Mexical	igin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modical Eventina function in the formal angles.	by F	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 Mo If Yes, Give Year or Dates:	1		1⊡Yes 2∏XN	o Specify:			Spe	ecify: wh	ite
21215-0036	2 hour	ted	15. Decedent's Edu	cation		16a. Dece	dent's Usual Occ	upation	4 = 6= #!:!		16b. Kind of	f Business/In	
218	ithin 7 ne. nan "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			kind of work dor DO NOT use reti	red)	it of workii	ng			
121	lled willed will have the		12 17. Father's Name (First, Middle, Last)			Ho	<u>memaker</u>	18 Moth	er's Name	(First, Middle,		Home	
Maryland	d be f ental I ked of	To Be	John Robert Cundi	ff						te Anni			een
ary	shoul and M s mar	F	19a. Informant's Name/Relationship (Ty				ng Address (Stre	et and Numb	er or Rura	al Route Numbe	er, City or To	wn, State, Zip	Code)
	and 2 ealth a n 27 is		John Clark Jones /	Son			rmont Pl						
Baltimore,	ges 1 If of H If iter or oth	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	1		sition (Name of natory or other p	:		ate		on - City or To	
Itim	iit. Pa urtmer urtant: njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		Mt.		el Cemet  Name and Add			1		ir, Ma	_ <del>-</del>
Ba	permi Depar Impor any Ir			- Do	wh				TATC.C	Comas Fu			nd 21009
1	Physician /Medical		23a. Part 1. Enter the hease, or complishook, or he had re. List only or immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line	ARY	Do not ent	er the mode of o	lying, such as	cardiac o	or respiratory ar	rest,	>	Approximate Interval Between Onset and Death
4	Examiner		Companielly list conditions	n.									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	сопвециы	nos of).							
	rtificate be executed ng physician and as the burlal-transit	xar	that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):							
68760,	te be e ysiciar e burk			d									
	rtifical ng phy as th	Medical	IE EENAN E.							•			
P.O. Box	ires that the death cer signed by the attendir i be detached for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal d	eath 3	☐ Ectopic pregna ☐ Other (specify,					Date of delive Month	ery Day Year
	that the ned by detact	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulti	ng in the u	nderlying cause	given in Part	I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
rds	w requires s been sig should be									1 🗆 Y	es 2 N	o 3∏ Prol	bably 4 ☐ Unknown
of Vital Records,	e fa has le 2	Completed								24a. Was autop perfor		tb. Were auto prior to co death? 1 \(\sum Yes\)	opsy findings available ompletion of cause of
/ita	hysician: Th nis certificate I director, pag	Be (	25. Was case referred to medical examiner?	tti-l.			T	NII .		(Check only o	ne)		
of \	Physi this c	은	1 ☐ Yes 2 No	fospital: 1 ☐ Inpatien 28a. Date of Injury		R/Outpatie	II 3 L DOA		T	me 5 Residence 128d. Describe h			(y)
on	Attending r death. ector After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	Year)	Injury	V	njuryat /ork? □Yes 2□		Zod. Describe i	iow injury ou	ourrou	
Division	Atter ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur		e, farm, str	eet, factory, offic	e		28f. Location (S		ımber or Rura	al Route Number,
ō	Hospital or 24 hours akte Funeral Dir stely filled in			NIPSEP	RACTI	THINE	R						
	24 hot 24 hot Fune etely fi	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of iner: On the basis of and manner stat	f my knowl examinatio	ledge, deat	h occurred at the	e time, date a ly opinion, de	and place, ath occur	and due to the red at the time,	cause(s) and date and pla	d manner as a ce, and due to	stated. o the cause(s)
	To the Hospital or Attending Phy within 24 hours arter death.  To the Funeral Director After the completely filled in by the funeral	Me	29b. Signature and title of sertifier				29c. Lice	ense number			29d. Date siç	gned (Month,	Day, Year)

Preis CRNP 2/10/09 R043580

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

T. PREIS 8839 WALTHER BLU BLUD

BALTO. MD 21234

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04317 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 0 Ye ar -30 P M FRNEST 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE LNIW OF MARYUAND MED CENTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □XM 2 □ F Months Days Hours Min. 83 212-32-4657 March 17, 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2 🌠 No Baltimore MD Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 United States 1109 Concordia Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Master Electrician School Board 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Hilgartner John Kolk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 Concordia Drive, Towson, Maryland 21286 Grace Elizabeth Kolk - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Lutheran Cem. : Feb. 16, 2009 Phoenix, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road, Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSI 2 WEEKS Due to (or as a consequence of): UND INFECTION MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events IPHERAL VASCULAR DISEASE MONTHS resulting in death) Last Due to (or as a consequence of): IE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

o the Hospital or Attending Physician: The law requires that the death certificate be executed

the burial-trai physician director, After this Director:

Physician

Examiner

/Medical

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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Physician/Medical

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Completed

Medical Certification: To Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumatic events.

within 24 hours a

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier,

29a. Certifier (Check only one)

LEEDOM MICHAEL

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

S. GREENE ST BACTEMORE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DWAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** INIVERSITY OF 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ₩ 2 □ F Months Days Hours Min. 79 Director 213-28-9656 March 4,1929 **Baltimore** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh amy injury or other traumatic event, the Medical Evantmer must be notified and injury or other traumatic event, the Medical Evantmer must be notified and. Director Maryland N/A Baltimore City Mo Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1205 Carroll Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 tyles 2 □ No If tes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ★ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2**X** No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Clerk Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Kastner Helene Kuehl 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Kastner / Sister 2043 Eagle Street, Baltimore, Maryland, 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Meadowridge Memorial 2/13/2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc 7250 Washington Boulevard, Elkridge, Maryland21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** COTONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): POTENSIDA Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. I Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by sate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 □ No 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 K. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Edunass

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10a-f. perFh G889 3/25/09 TT State of Maryland / Department of Health and Mental Hygieney 1 1 Q 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10, 2009 Month 4:20 a.M February D. Kane Shirley 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery 01ney Montgomery General Hospital 8. Date of Birth (Month, Day, Year) Aug. 23, 1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. Pennsylvania Vre 84 209-18-9992 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County State Scranton Silver Spring Lackawana Yes 2 NO -MD Montgomery 10f. Zip Code 18510 10g. Citizen of What Country? 10e. Street and Number 1037 N. Webster Ave. 20906 United States 3701 International Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 27⊈ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Retail Clothing Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fanny Harris Harry Hoder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17624 Shamrock Dr. Olney, Maryland 20832 (daughter) Linda Hofberg 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. Date 12, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dunmore, PA. Temple Israel Cemetery 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Ser. M00982 933 Gist Ave. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prelimonia ASPiration disease or condition resulting in death) Due to (or as a consequence of): UPOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) po-tensior Due to (or as a consequence of): 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 □Yes 2 ☑No eck only one) 5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred ocation (Street and Number or Rural Route Number, City or Town, State)

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division of Vital Records, P.O. Box 68760. attending pl cate has been signed by the page 2 should be detached funeral director, this After 1 n 24 hours after death. e Funeral Director: Af eletely filled in by the fur

**Physician** 

/Medical

Examiner

10a. **PA** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the studiest Exempted to the continue to the continue of the continue to the continu

Department of Health an Important: If item 27 is any Injury or other trau

**Physician** 

/Medical

12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n.

Pages 1 and 2 should

the Maryland

72 hours after death with

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Certification: To Be Completed by

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

within 24 ho

To the Fune

completely f

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2☑No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)	
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	1
		;
25. Was case referred to medical	26. Place of Death	n (Ch
examiner? 1 Yes 2 Mo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	n (Month, Ďay, Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	28d.
3 ☐ Suicide 6 ☐ Could not be determined		28f. L

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

10/09

DOC 68026

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Padmaja Bandi, M.D. 18101 Prince Philip Dr. Suite 315 Olney, MD 20832

State Registrar



and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0.32 A M Februar 2009 W /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesulle CSN Ridge If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Months 1 □ M 2 □ F 67 Yrs. 202-32-6744 20 1941 Director Feb PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Carroll Sykesville 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10f. Zip Code 21784 10e. Street and Number 7200 Third Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 → Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced tal Hygiene.
d other than "natura event, the Medical E Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) editor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Keil Irma Hannah ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave., M-311, Sykesville, MD 21784 Paul Bridge (executor) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important; If any injury or once. All County Cremation | 2-13-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Rome & Chapel 21. Signature of Funeral Service Licenses Pargraphight o P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Demento MONING disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Completed by Physician/Medical Examiner ending physician and use as the burial-trans Be ۵ Medical Certification:

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🌤 after death

Director: within 24 hours aft To the Funeral Di completely filled in

Cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery  Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No    24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		eath (Check only one)
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manne of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred
3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of my knowledge, death occurred at the time, date and plac miner: On the basis of examination and/or investigation, in my opinion, death occ and manner stated	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

29c. License number

400599443

,2009

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

lam ( Aver mo

FEB 1 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

295 5444

32. Registrar's Signature

Box 68760, P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the form filled in by the Hospital

27. Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier

cal

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

investigation

determined

6 ☐ Could not be

State Registrar

Avenue Sute 203 Baltmaro MD 21208 Veburan Buton 2835 31. Date filed (Month Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Tyes

2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

09-01246 Steven Lane Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n Lane		State of Mary I-For State Registrar	land / Departme <i>Certifica</i>			d Menta	al Hygie	ne Reg.	20	09	0432		
Physicia cal Exami	an/	Decedent's Name (First, Middle,Last)							2. Dete of Death Month Day February 11, 2009  3. Time of 1410				
		4a. Facility Name (if not institution, give street and 4028 Timothy Drive	4	o. City, Town, or Abingdon	Location of	Death		4c. County of Dea Harford	ath				
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F	7. Age (In yrs. last birth	hday) Yrs.	If Under 1 Yea Months Day			ate of Birth tober	17,195	Birthplace (State or preign Country) Maryland			
hours after death with the Maryland natural", or items 23a or 28a-f show any Examiner must be notified at once.	or	Usual Residence of Decedent  10a. State 10b. County  Md. Harford	10c. City, Town	wn or Location Abingdon						10d. Inside City Limits 1 Yes 2 XNo			
	by Funeral Director	1 Never Married 2 Married Armed	ed			10f. Zip Code  21009 Decedent of Hispanic Origin? (Specify Yes or specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2X No specify:							
Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  tant: If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed b	15. Decedent's Education (Specify only highest g  Elementary/Secondary (0-12) College  12  17. Father's Name (First, Middle, Last)	(1-4 or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Police  18.Mother's Name (First, Mic					16b. Kind of Business/Industry . MTA sle, Maiden Surname)				
2 should be filk and Mental H 17 is marked c natic event, th	To Be (	Elmore Lane 19a. Informant's Name/Relationship (Type, Print)			Address (Stree	at and Numb	er or Rural F	Llivan Route Numbe Baldwi	er, City or Town, Sta	ite, Zip Cod	e)		
permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic		Debbie Beck  20a. Method of Disposition  1 X Burial 2 Cremation 3 Remova  4 Donation 5 Other Specify:	20b. Place o	of Disposit ory or other	ion (Name of cer er place)	metery,	Date -14-2(	= 1	Timonium	<del></del>	ate		
permit. Departm Importa		21. Sign fure of Funeral Service Licensee  22. Name and Address of Facility 610 W. MacPhail Rd pchimunek Funeral Home Bel Air, Md  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart							Air, Md.	2101	4		
Medical aminer	Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as Due to (	ulmonary Thromboe a consequence of): a consequence of): a consequence of):	embolis	:m						Death .		
ath certificate be executed attending physician and or use as the burial - transi	Medical	Jab Was decedent pregnant in the past 12 months?	Ttem#11,#19 s, outcome of pregnancy birth gnant at time of death	Feta	rFH,G88		0/09 W	S	23d. Date of delive	ery Day	Year		
ing Physician: The law requires that the death certificate After this certificate has been signed by the attending physiciaral director, page 2 should be detached for use as the b	Completed by Phy	Part II. Other significant conditions contributing		g in the un	derlying cause o	given in Part	_		prior to ed? death?	autopsy find			
ling Physician: T After this certifice funeral director, p	o Be C	25. Was case referred to medical examiner? Hospital:	Inpatient 2 ER/Qu	utpatient		of Death (C	theck only o		esidence 6 V Oth	ner: Scene			
	-	27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No							28d. Describe how injury occurred				
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Foundation or Town, State)									Number, City		
To the Hos within 24 h To the Fur completely	edical	29a. Certifier 1 Certifying Physician: To the base one) 2 Medical Examiner: On the base and manne	s of examination and/or in	th occurre	on, in my opinion	, death occu	e, and due to orred at the t	ime, date an	d place, and due to	the cause(s			
12	Σ	29b. Signature and title of certifier  Paryel Turkell, m		29c. Licens				29d. Date signed (Month, Day, Year) February 12, 2009					
St	ate		use of death (Item 23a) t Medical Examiner Registrar's Signature		Penn Stree	t, Baltimo	re, MD 2	1201		· · · · -			

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 000 01.333 For

Physician
/Medical
Examiner

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evaninar must be notified at once. Be Completed by Funeral Director Baltimore, Maryland 21215-0036 ည **Physician** /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1 - State Registrar	Ce	rtificate of L	Death	Reg.	No.	043	20				
1. Decedent's Name (First, Middle, Last)	-			2. Date of Death	Day V	3. Time of D	eath				
MALEE LUMPKIN				Month FEBRUARY	10 2009	1:25	$\mathbf{A}^{M}$				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death						
Laurel Regional Hospital		Laurel	211		Prince George's						
4 T M OF T F	je (In yrs. last birthday) 65 <sup>Yrs.</sup>	If Under 1 Year     Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		rthplace (State or Foreign ountry)					
501-94-4913	65			Jan. 1, 1	L944   Tha	ailand					
10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City	Limits				
MD Prince George's	Laurel					1 □Yes 2	<b>☆</b> No				
10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?					
9461 Muirkirk Road, #102		20708			USA						
11. Marital Status 12. Was Decedent Armed Forces?	erican Indian,										
1 Never Married 2 Married 1 Tyes 2 No											
3 Widowed 4 Divorced Year or Dates:				401	l As	ian					
15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired,	urina most of worki	ng	. Kind of Business/Ir	dustry					
Elementary/Secondary (0-12) College (1-4or 5	i+) [	memaker			Own	Home					
17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid							
Wan Pakaew			Laa	Unknown							
19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street a			ty or Town, State, Zi	o Code)					
Ida Lumpkin/Daughter	9461	Muirkirk	Road, #1	.02 Lau	rel, MD	20708					
20a. Method of Disposition	20b. Place of Dispo				. Location - City or Te						
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		undel Cre		′2009 C	denton, M	D					
21. Signature of Funeral Service Licensee	2:	2. Name and Addres			neral Hom						
- aneco & Book	/	313 Talbo									
23a. Part 1. En er the disease, or complications that caused shock, or heart failure. List only one cours on each li	i the death. Do not en	ter the mode of dying	, such as cardiac o	or respiratory arrest,	s-na bec-t resolven	Approximate Interval Between Onset and Death					
Immediate Cause (Final disease or condition Re	spiratory										
resulting in death)	a consequence of):										
Sequentially list conditions b. AC	Acute Myocardial Infarction										
cause. Enter Underlying	Date to (or as a sometiquence of):										
that initiated events resulting in death) Last	nal Failur a consequence of):	e Acute	and Chr	onic							
200 (0) (0)	abetes Mel	1.1+11.0									
d	abetes Mel	IILUS									
IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome	of pregnancy				22d Date of deliv						
in the past 12 months?	2 ☐ Fetal death 3 [	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deliv Month	Day <b>Y</b> e	ar				
1 ☐ Yes 2 ☐ No 4 ☐ Fregnant a 9 ☐ Unknown											
Part II. Other significant conditions contributing to death b	ut not resulting in the u	inderlying cause give	n in Part I.	23e. Did tobaco	co use contribute to t	he cause of dea	ath?				
Hypertension				1 ☐ Yes	2 🗆 No 3 🗆 Pro	bably 4 🔀 Uni	known				
Hyperlipidemia				24a. Was an	24b. Were auto	ppsy findings av	ailable				
				autopsy performed	?   death?	mpletion of cau	se of				
25. Was case referred to medical		-	26. Place of Death	1 ☐ Yes 2 🛭 (Check only one)	140 TLITES	2 140					
examiner? 1 ☐ Yes 2 🖾 No Hospital: 1 ☐ Inpatie	ent 2X ER/Outpatie	nt 3 DOA Othe	f: 4 ☐ Nursing Hor	me 5 Residence	e 6 ☐ Other (Speci	fy)					
27. Manner of Death 1 X Natural 5 □ Pending (Month, Da	ıry 28b. Time o	of 28c. Injury Work	at 2	28d. Describe how in	njury occurred						
2 Accident investigation			es 2□No								
3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Num. City or Town, State)											
29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner state.	f examination and/or ir	th occurred at the tim nvestigation, in my op	e, date and place, inion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due t	stated. o the cause(s)					
29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Month,	Day, Year)					
1 Vary/4_	1 / Wary/42 - M.D. D0016605 2/00/05										
30. Name and address of person who completed cause of d	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
Wang Koon, MD 7300 Va	an Dusen Ro	oad, Laure	1, MD 20	0707		1.					
31. Date filed (Month, Day, Year) 32. Registro	ar's Signature	11 1									
FEB 1 3 2009 (2000)	1 1. 18 W	A CONTRACTOR OF THE PARTY OF TH									

State

Registrar

09-01158 Chau Lo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3	tate	of	Maryland	/ Department	of Health	and M	1ental I	Hygiene

2009 04324

	Registrar Reg. No.									, 0 ,				
Physician/		1. Decedent's Name (First, Middle,Last)						. 2.	Date of De Month	ath Day	Year		ime of Death	
ledical Examine		1 Fohru						ebruary 8, 2009			740 hrs			
	4a. Facility Name (if not institution	on, give street and number)			City, Town		cation of I	Death			ounty of De		A-1	
	Baltimore Washington Medical Center Glen Burnie								Anne Arundel					
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birtho	lay)	If Under 1	_	If Under		8. Date of B	irth(MM/DE			ce (State or Vietnam	
Director	220-06-5416	1 M 2 X F	68	Yrs.	Months [	Days	Hours	Min.	Feb.	)				
	Usual Residence of Decedent													
any	10a. State 10b. County		10c. City, Town of	Locatio	n								. Inside City Limits	
r Ge nd	MD Anne	Arundel	Pasad	ena								1	X Yes 2 No	
Aaryland 28a-f show auy <u>1 at ouce.</u>	10e. Street and Number				10f. Zip Coo	le				10g. Citize	n of What C	Country?		
th the Maryland 23a or 28a-f sho notified at once	354 Nature Wa	alk Lane			211	22			1.	11	SA			
s 23a		12. Was Decedent i	Ever in U.S.		Decedent of	f Hispa					1. Race - Ar		Indian, Black,	
r death with or items 23	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, e								White, etc	C.				
rer de								pecify:	Viet	namese				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Commisted by Finneral Director		or Dates: ecify only highest grade com	pleted) 16a. D	ecedent's	s Usual Occ	upatio	n (Give ki	nd of wo	rk done	16b. Kin	d of Busine	ess/Indus	stry	
within 72 hour giene.  Let than "natue E. Medical Example ed.	Elementary/Secondary (0-12	) College (1-4 or 5	5+) du	iring mo:	st of working	life. L	O NOT u	se retire	d)					
5-0036 led within 72 Hygiene. other than '	12th	4		Lau	ndres	S				(	Comme:	rcia	l Laundry	
5-0036 liled within 7 Hygiene. Il other than the Medica	17. Father's Name (First, Middle	e, Last)			· ·	18	3.Mother's	Name (	First, Middle	, Maiden Si	ırname)			
215 be file mtal H rked o	Kham Lo Len T							i Tru						
2121 2121 buld be fi I Mental i market ic event,	19a. Informant's Name/Relation	ship (Type, Print )	19b.	Mailing	Address (S	Street	and Numb	er or Ru	ral Route N	umber, City	or Town, S	State, Zip	Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hyggene. Important: If item 27 is unarked other than injury or other traumatic event, the Medical To Re Comple	Phong Lo / S	Sister			ature							2112		
e, P	20a. Method of Disposition		20b. Place of cremato			f ceme	etery,		Date	20c. Lo	cation - Cit	City or Town, State		
Baltimore, pernit. Pages I ar Department of Hec Important: If ite Injury or other tr	1 X Burial 2 Crematic		are I	•	Ceme	ter	v	2/1	2/09	La	urel,	MD		
Itin lit. P. urtme ortan	4 Donation 5 Other 3	Specify: e Licensee	1 2 2							n Fune	eral 1	Home	, P.A.	
Balti permit. Departn Imports injury o	Comoro	A Dort	M01103		3 Tal							0707		
Physician	23a. Part / Enter the disease, of	or complications that caused	the death. Do not	enter th	e mode of dy	ying, s	uch as ca	rdiac or	respiratory a	rrest, shoc	k, or heart		pproximate Interval Between Onset and	
Medical	failure. List only one caus	Cuberoebnoid H	lemorrhage									2010	Death	
taminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):													
	Sequentially list conditions, b. Ruptured Berry Aneurysm													
Š	if any, leading to immediate	if any, leading to immediate Due to (or as a consequence of):												
	[ (Disease or injury that initiated	C	equence of):			_								
		d.	, ,											
760, icate be executed physician and the burial - transi	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in	AMENDED												
760, ficate be ex	IF FEMALE:	23c. If yes, outcor	me of pregnancy	-		_				23d.	Date of del	livery		
876 tifficate ng phy as the	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month I								Day	Year				
Box 68 death certif	yes 2 V No 9 U	-1	time of death 5	Oth	er (Specify)					ì				
P.O. Box 687 s that the death certifify gred by the attending e detached for use as t		9 Ulkilowii			1 1 1 1 1 1 1 1		in Dec	4.1	230 Die	1 tobacco II	se contribu	te to the	cause of death?	
o hat th		litions contributing to deat	n but not resulting	in the u	noenying ca	use gr	veninrai	Į I.					y 4 V Unknown	
S, P.C.									1 24a. Wa			_	sy findings available	
ords, w requir is been s should									au	topsy	prio	r to com	pletion of cause of	
ecc he lav tte ha	Completed by									rformed? s 2 No	dea 1 ✔	Yes	2 No	
of Vital Records, ng Physician: The law requir Mher this certificate has been suneral director, page 2 should the control of t		cal			26.		of Death (	Check o	nly one)					
Vita visicia visicia visice direc	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 🗸 ER/Ou	tpatient	3 DOA	, (	Other 4	Nursing	Home 5	Residen	ce 6 (	Other:		
J of Ling Phy After the funeral	27 Manner of Death	28a. Date of Inju		ime of Ir	njury 28c	. Injur	at Work	?	28d. Describ	e how injur	y occurred			
endin	1 Natural 5 Pe	nding			1	Y	es 2	No						
Division tal or Attendi us after death. al Director: /	2 Accident Inv	vestigation 28e. Place of Ir	njury - At home, fa	rm, stree	et, factory, of	fice bu	uilding, etc	j.		n (Street an	d Number	or Rural	Route Number, City	
Divis ital or At us after d ral Direc		termined (Specify)							OI TOWI	i, State)				
Hosp Hosp		Physician: To the best of m	ny knowledge, dea	th occur	red at the tin	ne, da	te and pla	ce, and	due to the c	ause(s) and	manner as	s stated.		
Division of Vital Records, P.O. Box 68  To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  Within 24 hours after death.  The Funeral Directors. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	(Check only one) 2 Medical Expose 29b. Signature and title of certifying	xaminer: On the basis of exa and manner stated.	mination and/or in	vestigat	ion, in my or	oinion,	death occ	curred at	the time, da	ate and plac	e, and due	to the c	ause(s)	
F.Y.F.S	29b. Signature and title of certi				29c. L	icense	number			29d. D	ate signed	(Month,	Day, Year)	
	O.C.M.E.							February 9, 2009						
	30. Name and address of pers	on while it pleted cause of	death (Item 23a)			-						-		
į.	Russell Alexander M			111	Penn Str	reet,	Baltimo	re, MI	21201					
Sta	te 31. Date filed (Menthe Day, Yea	32. Registra	ar's Signature	. 20	E					•				
Registr		JU9 LAMONAS	ft. 190	the state							Educati			
			5,6								DUIVIE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9, 9:00 A 2009 CAROLYN ELIZABETH LEE FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3568 Elmora Ave. Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ XT Yrs. Director 215-14-8583 89 12, 1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "hedical Examinat must be notified at opine. 1X Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 3568 Elmora Avenue 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 XWidowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Elizabeth Freund Adam (UNK) Tiedebohl ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William C. Lee / Son 3568 Elmora Avenue, Baltimore, Maryland, 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/12/2009 Baltimore, Maryland Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland, 21009 23a. Part 1. Enter the illisease, or complications that caused the deuth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 1 ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** c oron airi disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any, basing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tou 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe mure b. 2 🗆 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760. P.O. I Division of Vital Records. eral Director: A death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a

> State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year) \_\_\_\_

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

neem 4701 0001 32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Thoustes St

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 9, Barnzie Nell Lewis 2009 8:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔯 F Director 214-34-2662 80 May 18, 1928 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Barnett Lane Funeral Apt. 203 21001 2 should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White þ 3X Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Production Line Shoe Manufacturing is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Liscoe Akers Viola Elizabeth Asberry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and pepartment of Health at Important; If item 27 is any Injury or other trauonce. Sandra Sue Ward / Daughter 302 Gadwall Ct., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdns 2-12-09 Aberdeen, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dulmonary **Physician** OUT FUCTIVE Chronic disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t performe 2 No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director; Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO 6547 09 2 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

SEORGE A.

31. Date filed (Molnin, Day, Year)

HEARY

MD

32. Jegistrar's Signature

501 S. UNION Ave HAVRE de GRACE MO 21078

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Phys	sician
/Me	edical
Exa	miner

**Funeral** 

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exeminational be notified at

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

burial-transi and Division of Vital Records, P.O. Box 68760, attending physician

e Hospital or Attending Physiclan: 24 hours after death. e Funeral Director: After this certifica To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 20

1. Decedent's Name (First, Middle, Last) 2. Date of Death PM Barbara Lou Belle Mallery February 2009 9:04 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Parkville 2900 Alden Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/13/19 3 0 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min 1 ☐ M 2 💢 F Baltimone, MD 213-30-3345 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Parkville 1 ☐ Yes 2√∑ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21234 2900 Alden Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tyes 27 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 □Yes 2X No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Belle Jeanne Adee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marjorie Lotz/ Daughter 2518 Perring Woods Rd. Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD  $\bigcirc$ 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Crema 8800 Harford Rd. Parkville, struck, or heart failure. List only one cause on each line.

Evans Funeral Chapel & Crema 8800 Harford Rd. Parkville, or heart failure. List only one cause on each line.

Importante Cause (Final discusse or condition resulting in death)

a. Cour E (724) Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 💆 No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P. USDAKK MO FEBRUARY 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. BOUL PLACE BALTIMONE MO 227 32. Registrar's Signature / State CHESCANS. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 04328 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Esther Mockard 2009 February AM 2:30 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2612 Canterbury Road Parkville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F Days Hours 217-09-5445 102 rs. 08/13/1906 Masl in, OH Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore Parkville 1 ☐ Yes 2 ▼No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2612 Canterbury Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augstus Fetrow RosellaSchuler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Rumel/ Daughter 2612 Canterbury Rd. Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/16/2009 Pankwood Cemetery Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans funeral chapel & Cremetion Services 8800 Harford Rd. Parkville, MD 21 2 34 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final diseas or condition resulting in death) Cendy NYONIC Due to (or as a consequence of): eneraliz atheroaderatic vascular discale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Year Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Be Completed by

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Funeral

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ith and Mental Hygiene.
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permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ed by the attending physician and detached for use as the burial-transit

Box 68760,

P.O.

Division of Vital Records,

death.

Physician/Medical Examiner Be Completed by

Medical Certification: To

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

Mewhood

6 Could not be determined

Morustrul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAD 32. Registrar's Signature

or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the completely

> State Registrar

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

608 Edgevale Roud, Bultimore

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		State Registrar  1. Decedent's Name		e Type 68882 De Felatoral Ma		Certifi Laugh1i	cate of	Death	2. Date of De	Reg. No.	_ 0 0 7	3. Time of Death
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ked othe	Be	17. Father's Name <b>Alva</b> <del>Alua</del> Wh:	(First, Middle, La	ast)			18. Mother's Name (First, Middle, Maiden Surname) Minnie Steele					
Ith and M		19a, Informant's N	ame/Relationship	o (Type. Print) nlin—Son	1	19b. Mailing Ad 9641 A	ddress (Street	and Number or	Rural Route Numb	er, City or M <b>ill</b>	Town, State, Z S • Md	<sup>(ip Code)</sup> 21117
ayes rate of Heart: If item 3		20a. Method of Dis	position	□ Removal from State	20b. Place ceme Mead	e of Disposition etery, cremator OWILGE	ry or other plac	ce)	Date 11/2009	Elk	ation - City or Tridge	Fown, State
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this certificate has been signed by the attending physician and mind director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Immediate dause disease or condition resulting in death)  Sequentially list confidence in death, leading to improve the cause. Enter Under Cause (Disease or that initiated events resulting in death)  IF FEMALE: 23b. Was deceden in the past 12 1	Arministration of the predict of the predict of certifier	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence a consequence of pregnancy 2 Fetal deat time of deat time of deat to the control of examination and the control of examination tated.	Do not enter the coordinate of	topic pregnancher (specify)	cy  ven in Part I.  26. Place of Cher: 4 Nursing ry at rk?  1Yes 2 No  time, date and pl opinion, death o	23e. Did 1	tobacco us Yes 2 an psy ormed? 2 No one) idence 6 how injury (Street and wn, State) e cause(s), date and	3d. Date of del Month  e contribute to Month  24b. Were au prior to death? 1 Ves  Other (Specocurred)  Number or Ru	Approximate Interval Between Onset and Death  Ivery Day Year  the cause of death? obably 4 Unknown topsy findings available completion of cause of 2 No  In Pay No Iver Number, as stated. to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 **Physician** 2009 Stephanie 1:30a. M Arania McDowell 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Nursing Home Year) 59 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, O2 18 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2√□ F 214-80-7022 Director 49 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinal must be notified at 1 V Yes 2 □ No Director Pikesville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 4845 Hawksburg Road 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Black Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) 2yrs Elementary/Secondary (0-12) n and Mental Hygiene. is marked other than Engineer 12th grade Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Patricia Carter ္ရ Stephen McDowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 4845 Hawksburg Road, Pikesville, Md 21208 Patricia McDowell-Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ÷ Department of Important; If it any injury or o oonce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 2/23/09 Owings Mills, Md | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 23a. Part 1. Enter the disease, or complications that caus at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final discrete se or condition resulting in death) Adonocoromomao **Physician** Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performe Vital 2 No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specific) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) 10x1 N. Charle St. Belto Md 2,201 BMC 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FER 3 2009 Registrar

DHMH 17 Rev 1/2001

200

McDowell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1/ per th g888 2-13-09 vt.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Yea Month 944 PM Physician Merle 8 2009 nnel tebruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 1 🗆 M 218-28-5154 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? items 23a or Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1. Marital Status Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 ö 1 ☐ Yes 2 XNo Specify Specify Completed by Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industr 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) 19 ary (0-12) College (1-4 or 5+) other than 18. Mother's Name (First, Middle, Maid 17. Father's Name (First, Middle, Last) Be r and Mental F Scott traumatic Print) 19b. Mailing Address (Street ar 19a. Informant's Name/Relationship (Type. 27 ortant: If item 2 injury or other Baltimore, 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State Important: It any injury o once. Department 5 Other (Specify) 4 Donation 21. Signature of uneral Serv 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not ente Immediate Cause (Final hemmorkag **Physician** subaracunoid day disease or condition resulting in death) Due to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of requires that the death certificate be executed that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown P.O. signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 3 Probably 4 Unknown 2 🗌 No 1 \sum Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 2 🗌 No Yes . Yes 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 1 Inpatient 2 - ER/Outpatient 3 🗆 DOA 6 Other (Specify) ဂ္ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: ul or Attending Poster death. 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ROS-000 006,0 MD Februa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Melissa Pant The Johns Hopkins Hospital 31. Date filed (Menths Day, Year) State garle Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Thomas Harvey Morris February 11 2009 /Medical 5:15 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7901 Aylesford Lane Laurel Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min 1 □ M 2 □ F 578-50-1911 Director 71 Pennsylvania 8/1/1937 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Mudical Examinar must be not ined at Maryland Prince George's 1 ☐Yes 2 No Directo Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7901 Aylesford Lane 20707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 and 2 should be filed within 72 hours after or Health and Mental Hygiene. em 27 Is marked other than "natural", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No White If Yes, Give Year or Dates: Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense 12 <u>Meat Cutter</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Ellsworth Morris Mary Elizabeth O'Reilly ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melva Morris - Wife 7901 Aylesford Lane, Laurel, Maryland, 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory: 2/13/2009 Glen Burnie 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd.Elkridge, Maryland 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and Box 68760, physician Physician/Medical the 238 attending p F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown cate has been s, page 2 should 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 XiNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and

State Registrar 31. Date filed (Month, Day, Year) FFB 1 3 200

32. Registrar's Signature

parkel

Green Street

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	irtment of tificate o	Health of Death	and M	ental Hy	giene Reg. No	2009	04333
			Decedent's Name (First, Middle, Last)							2. Date of De			3. Time of Death
	Physicia /Medic		Colette Weinheimer M	ertes						Februar	y 9 <sup>Day</sup>	<sup>y</sup> 200 <sup>9</sup>	11:02 A M
	Examin		4a. Facility Name (If not institution, give s Gilchrist Hospice	street and number)			4b. City, Town	, or Location <b>VSON</b>	of Death		4c.	County of Death	
H	Funeral Director		270 03 0700	7. Ag	e (In yrs. Ia	ast birthday) Yrs.	If Under 1 Ye		24 Hrs. Min.	8. Date of Bir (Month, Da August	rth ay, Year) 29,19	9. Birtl	hplace (State or Foreign untry) h10
	w and		Usual Residence of Decedent  10a. State 10b. County		10c. City.	. Town or Lo	cation						10d. Inside City Limits
	/laryla	ō	Maryland Howard		1	Ellicot							1 □Yes 2 ▼No
	the f	irec	10e. Street and Number			IIIIICO	10f. Zip Cod	e			10g. Cit	tizen of What Co	untry?
	h with	Funeral Director	12193 Mount Albert Roa	ıd				21042				U.S.A.	
	deat ems	ner	11. Marital Status	12. Was Decedent	Ever in U.S	13.	Vas Decedent of Yes, specify C	of Hispanic Or	rigin? (Spe	city Yes or No	p-	14. Race - Amer Black, White	
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_	2 should be filed within and Mental Hygiene. is marked other than "aumatic event, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Teach	DO NOT use ret	ired)			Educ	cation	
pu	e filec al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, Last)							(First, Middle		Surname)	
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	d 2 sh th and 7 is π traum		19a. Informant's Name/Relationship (Ty) Thomas Mertes (Son)	pe. Print)			-					or Town, State, Z Maryland 2	,
	1 and 2 Health tem 27 i		20a. Method of Disposition		20b. Pla		sition (Name of natory or other p			ate		ocation - City or 7	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan postarment of Health and Mental Hygiene. In the post series 23a or 28a-f show Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.		1 ☐ Burial 2XX Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			ntic Cre	matory	E E	2-12-2			Burnie, M	
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				cations that caused be cause on each li	the death.	. Do not ent	er the mode of	dying, such as	s cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
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-	/Medical Examiner		resulting in dealing	Due to (or as	a consequ	ence of):							
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8760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as	a conseque	ence of):							
687	ficate physi s the i	dical											
O. Box (	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{NNo} \) 9 \( \text{Unknown} \)	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🔲 Fetal	death 3[	Ectopic pregna Other (specify					23d. Date of deli Month	ivery Day Year
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of Vital Record	w require s been sign should b		*******							1 🗆	Yes 2	No 3□ Pr	obably 4 Unknown
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V:t	Physician: this certific al director, I	Be	25. Was case referred to medical examiner?	lospital:		-5/0-1	it 3□ DOA	Othor:		(Check only		o Thou	
of		n: To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of	28c. II	njury at		ne 5 ☐ Hes 28d. Describe		6 Other (Spec	oily) V W S J U C
ion	Attending F death. ctor: After y the funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ıy, Year)	Injury		Vork? □Yes 2□	]No				
Division	or / or / or / or or /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At hor c. <i>(Sp</i> ec <i>ify</i>	me, farm, str	eet, factory, office	ce	2	86. Location City or To			ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier (Check only one)  Check only one)	sician: To the best ner: On the basis of and manner st	of examinati	vledge, deat ion and/or in	n occurred at th	e time, date a ny opinion, de	and place, a	and due to the ed at the time	e cause(s , date an	s) and manner as d place, and due	stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 24a,25,27,28a-f,30 per me, 2888, verb.,02/12/09dhb Certificate of Death For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Mul January en .cala /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Johns Hopkins at Baltimore Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 1 2 □ F Months 49 223-02-4441 Director Marocco Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? ō It alcyon 23a Funeral or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced *white* "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Self Employed sthier 12 should be filed with and Mental Hygier
7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ 19a. Informant's Name/Helationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum 35 Black Bear Trail Hendersonville, NC 28739 tt enru 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1. 28.2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funcius Services 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** xsanguination disease or condition resulting in death) Mr. Lucké /Medical Due to (or as a consequence of): Examiner Lieted aceration to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) acerationsto and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No detached 9 Unknown à s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autonsy perforn 2**X** No Division of Vital<sup>(</sup> 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examine: 1∰Yes 2∐No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Found: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation within 24 hours after users...

To the Funeral Director: After the function of 01/22/2009 12:38 p<sup>M</sup> 1 ☐ Yes 2X No Subject cut self. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2403 Halcyon Ave. ospital or At determined 4 ☐ Homicide Home Raltimore, MD To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) January 22,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Feldman, MD, Johns Hopkins at Bayview Hospital Isadore 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 04335 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VARDIA U 2004 24 Richard E. Moore Sr /Medical 4a. Facility Name (If not institution, give street and number)
VA MARYLAND HEALTH CARE 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SYSTEM PERRY INIOA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**) M 2□ F Director 722-12-3885 82 Sept 23, 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director MD 1 □Yes 2√2 No Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5213 5th Avenue 20737 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XiYes 2 ☐ No If Yes, Give Year or Dates: 143-64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) flight mechanic transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Patrick Moore Margaret Angela McCulley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Charlene Cahill/daughter 4410 Oglethorpe Street #716 Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ld S. Warde 21. Signature of Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street Pirector inn Baltimore, MD 21201 23a. Part Enter the dis se, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

ENRINIC 06.5TRUETIVE FULMINARY 1.5 Approximate Interval Between PULMONARY DISEASE Oncettand Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No cate has t page 2 s 24a. Was an this certificate rmeg / 2 A No 1 □ Yes Division of Vital Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ö To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) VA010 1058 1201 February 12, 2009 2 han 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARTH EART, PERRY ADINT, MD 21902

Registrar

State

31. Date filed (Month, Day, Year)

5

RICHARD

MOORE,

KNOWN TO

NAME

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** T. 2009 Year Sr. Kenneth McConnell Feb. 10 10:50២ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 204 Middle Way Road Middle River Baltimore 8. Date of Birth (Month, Day, Year) July 24,1926 Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 XM 2 □ F 218-22-5175 82 **Director** MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at MD Baltimore Director Middle River 1 ☐ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 204 Middle Way Road 21220 23a USA Funeral or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: Specify: White <u>چ</u> 3 Widowed 4 Divorced marked other than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Chief Engineer 12th Board of Education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental item 27 is marked o Elizabeth Augusta McNeave William McConnell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores McConnell /wife Middle Way Road Baltimore MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of I Important; If it any injury or o 1 ☐ Burial 2XX remation 3 ☐ Removal from State Bayview Crematory 2/14/09 Baltimore MD 4 Donation 5 DOther (Specify) 21. Signature of Fu eral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Eggax 21221 23a. Part 1. Enter the disease, or constitutions that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ois **Physician** 070 120V disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o<sup>i</sup> 9 Unknown 9 🗌 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed: certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 🔾 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) e Hospital or Attending P 24 hours after death.
e Funeral Director: After t letely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar

31. Date filed (Month, Day, Year)

FERDS

Revise th

Point

BIVO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

XO5

32. Registrar's Signature

N

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician   Medical   Ricky Allen Michels   Recommendation   Ricky Allen Michels   Recommendation   Recommen	e City Limits Yes 2 18 No
4a. Facility Name (If not institution, give street and number)  4a. Facility Name (If not institution, give street and number)  619 Hartwood Lane  So. Social Scurity Name  6. Sox  170 M 2 F 49 Yrs.  180 M 2 F 49 Yrs.  190 Maryland	ate or Foreign and e City Limits Yes 2 12 No
Social Security Number   6. Sex   7. Age (in yrs. last birthday)   1f Under Year   f Under 24 Hrs.   8. Date of Birth   Months   Days   Hours   Min.   July 26, 1959   9. Birthplace (Str. Country)   Mary 1   10a. State   10b. Country   10c. City, Town or Location   10a. State   10b. Country   10c. City, Town or Location   10d. Inside   10b. State   10b. Country   10c. City, Town or Location   10d. Inside   10b. State   10b. Country   10c. City, Town or Location   10d. Inside   10b. State   10b. Country   10c. City, Town or Location   10d. Inside   10b. State   10b. Country   10c. City, Town or Location   10d. Inside   10b. State   10b. Country   10c. City, Town or Location   10d. Inside   10c. City, Town or Location   10d. Inside   10b. Country   10c. City, Town or Location   10d. Inside   10b. Country   10c. City, Town or Location   10d. Inside   10c. City, Town or Location   10c. City, Town or Location   10d. Inside   10d. Inside   10d. Inside   10d. Inside   10d. City, Town or Location   10d. City, Town or Locati	e City Limits Yes 2 18 No
Social Security Number   Social Security Num	e City Limits Yes 2 18 No
Superior Control of	e City Limits Yes 2 18 No
10a. State   10b. County   10c. City, Town or Location   10d. Inside	Yes 2 No
Thomas Peter Michels  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Mailing	n,
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4 Donation 5 Other (Specify)   Hilltop Service Corp. 2-14-09   Towson, Marylan	
4 Donation 5 Other (Specify)   Hilltop Service Corp. 2-14-09   Towson, Marylan	
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4 Donation 5 Other (Specify)   Hilltop Service Corp. 2-14-09   Towson, Marylan	d
Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Onset a Due to (or as a consequence of):  Approximately Rd., Ablingdon, MD 21009  Approximately Rd., Abl	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval disease or condition resulting in death)  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval interval disease or condition resulting in death)  Approximately list acaditions  Approximately list acaditions  Due to (or as a consequence of):	
Physician disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	mate Between
/Medical resulting in death)  Due to (or as a consequence of):  Examiner  Sequentially list conditions	and Death
Sequentially list conditions b.	4.0.
Sequentially list conditions, if any, leading to immediate cause. Enter Uncorpting that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
that initiated events that initiated events resulting in death) Last Due to (or as a consequence of):	
Political politi	
Signature of the state of the s	
23b. Was decedent pregnant in the past 12 months?	Year
O of the first of	
1   Yes 2   No 3   Probably 4	Unknown
To see the second of the secon	ngs available of cause of
The state of the s	
25. Was case referred to medical examiner?  1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	SPICE
1 Inpatient 2 ER/Outpatient 3 DOA Working Home 5 Residence 6 Softher (Specify) LIO  27. Manner of D ath 1 Inpatient 2 ER/Outpatient 3 DOA State of Injury 28b. Time of Injury at Work? 27. Manner of D ath 28b. Time of Injury at Work? 28b. Time of Injury at Work? 28c. Injury at Work?	
O by the state of	
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The latter of the latter of	Number,
29c. License number 29d. Date signed (Month, Day, Year	
	ise(s)
Dendall Rtaller 225643 02/12/201	ise(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print).  Hendell R. Faullcaer MD/11311 McCormide Rd/Hunt Valley MD 210.	ise(s)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 04338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician bac FEBRUARY ona /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Med. Center Sex 7. Age (In yrs. last birthday) Himore nne Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 1 M 2 □ F Months Days Min. 1934 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Examinar must be notified at Baltimore 1 PYes 2 □ No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3123c USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 No Novy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo Specify: If Yes, Give Year or Dates: Be Completed by 3 Widowed 4 Divorced W 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 ſЪ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hi Important: If Item 27 is marked oth any injury or other traumatic event ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Speuse 31330 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jalto, 4 Donation 5 Dother (Specify) a 1-Comercatory 21. Signature of Runeral Service License 22. Name and Address AM 1232 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** utropial alas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner and the standard of the standard cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has page performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🗖 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I 29c. License number 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) WD D00.38 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINGH SIDHUMD 208 Crain Hay SW Year) 2009 31. Date filed (Month, Day, Registrar's Signature State FEB13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Dav Year **Physician** margaret E. Pierce 5:35 A M 02(Feb) 08 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Union Memorial If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) 220-07-5587 1 □ M 2√E)√E Yrs. MD 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evaring must be medical and once. 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Funeral Director 1 X Yes 2 ☐ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2318 Aiken Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MIL (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Allie Dorsey Alfred Pierce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woods-in-ta Victorine C. 4608 72nd Avenue Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-13-2009 Anne Arundel Co, MD Cedar Hill Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H MD 21202 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiomyopus Vear /Medical Due to (or as a consequence of): Examiner Renal ronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events equentially list conditions Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death P.O. I the i ∐Yes 2 Mo 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 2 **Z**No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D AT2438964 02-08-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bara Kat Baltimore, MD Union Memorial Shadi Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Badrolmoluk Pourhamidi 8:00 A /Medical January 29 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Bethesda Bethesda Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 1 F Months Days Hours Director 214-11-0339 98 February 7 1910 Iran Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examinar mata be notified Director 1 ☐ Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iran Funeral 6530 Democracy Blvd. 20817 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 △No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Mehdi Moayedi ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 item 27 i Abol Pourhamidi - son 7312 Helmdale Rd. Bethesda, MD 20817 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) February 1 2009 Falls Church, VA 22. Name and Address of Facility National Funeral Home Signature of Funeral Service Licensee 7482 Lee Highway Falls Church, VA 22042 eck 23a. Int 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physiclan** disease or condition resulting in death) Due to (or as a consequence of): THRIVE /Medical Examiner Sequentially list conditions, if any, leading to immediate Lause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed physician and the burial-transl Due to (or as a consequence of): P.O. Box 68760, signed by the attending I be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by s been si should 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsy 1 ∐Yes 2 X No 1 ☐ Yes 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-17874 1-29-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD AVE, COTTAGE CITY S.M.NAYAR 3717 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 5:35 a<sup>M</sup> Scott Pullen Feb. Evelyn Naomi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖫 F Months Days Hours Director 228-16-3562 85 5 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at **Funeral Director** Maryes 2 □ No Rockville MD Montomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 20852 USA 11004 Arroyo Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 1 □Yes 2 □No Completed by Specify Specify. 3 ₩ Widowed 4 □ Divorced "natural" Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housing Authority Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked פ Evelyn F. Carter ပ္ George Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Rockville MD 20852 Tiffini Lucas M.D. 11004 Arroyo Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7 2009 Salem, 4 ☐ Donation 5 ☐ Other (Specify) Sherwood Memorial Feb 22. Name and Address of Facility Hamlar - Curts 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 | Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Be Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pertension 1 ☐ Yes 1 ☐ Yes 25/ Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending **Iniury** investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours of the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 22966 2009 30. Name and address of person who completed cause death (Item 23a) (Type, Print) lhomas 31. Date filed (Month, Day, Year) \* Registrar

DHMH 17 Rev 1/2001

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amend item, 7 per fb. 9888 2-13-09 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Willis Jackson Pennington 4:26 a<sup>M</sup> February 11. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1120 Poplar Grove Road Street If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral ★**□ M 2□ F 74 Director Virginia 226-38-0641 Usual Residence of Decedent 24, 1934 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Completed by Funeral Director Maryland Harford
10e. Street and Number Street 10f. Zip Code 10g, Citizen of What Country? 21154 1120 Poplar Grove Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ⊋No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura Gay Roark Lillard Odell Pennington ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. Pennington / Spouse 1120 Poplar Grove Road, Street, MD 21154 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 2-16-09 Bel Air, Maryland 21. Some use of Fundal Salva Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Inter the disease, or complications that caused the yeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Came Final disease or condition resulting in death) **Physician** Mydardin /Medical Due to (or as a consequence of): Examiner Commony Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 178/2/2m 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No After this certificate ha funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nn 32. Registrar's Signature 31. Date filed (Month, Day) Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 0:50 PM 02 09 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Franklin Square
5. Social Security Number 6 Rosedale Hospital Center ge (In yrs. last birthday) If Under 24 Hrs Date of Birth Month, Day 9. Birthplace (State or Foreign **Funeral** Months Hours 1 ☐ M 2 🗹 F Days Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 28a-f shov 1 ☐ Yes 2 Mo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 | Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) Elementary/\$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RADA JACKSONVILLE, F 20b. Place of Disposition (Name of emetery, crematory or other) Date 20c. Location - City or Town, S ate 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Unisage or highly that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit L<sup>B</sup> Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? 1 Yes 2 No death 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**⊡**√√0 1 ☐ Yes 1 Ampatient Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) after death. 27. Mann f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours at To the Funeral C completely filled i e

> State Registrar

(Check only one)

29b. Signature and title of certifier

Simon

FEB 1

3

31. Date filed (Month, Day, Year)

5

29c. License number

Drive

Square

29d. Date signed (Month, Day, Year)

Baltimore, Hd 21237

and manner stated.

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32 Registrar's Signature

ranklin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	State of Mary				Mental Hy			04344
			Registrar		Cei	rtificate of	Death ————	0.0-4/0		2009	
	Physicia /Medic		1. Decedent's Name (First, Middle, La William A. Rob	inson				2. Date of De Month Februa	Day	2009	3. Time of Death 4:00 P M
-	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		th	4c.	County of Dea	
seed.		-	6023 Montgomer			Caton If Under 1 Year	nsville				imore
	Funeral Director		219-28-3265	Sex 7. Age (III 7. Age (III 7.	n yrs. last birthday)  Yrs.	Months Days	Hours Min	8. Date of Bi (Month, D Jan.	$\stackrel{rth}{31}, \stackrel{Year}{1}$	934 Mai	thplace (State or Foreign ountry) ryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits
	/aryl	ō	Maryland Baltim			sville					1 □Yes 2¾ No
	the N	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Co	ountry?
	should be filed within 72 hours after death with the Maryland Mad Mently Hygiene. Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, it a file files Ext. ill or must be notified at		6023 Montgomery			2	21228			USA	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? ( an, Mexican, Puer	Specify Yes or No to Rican, etc.)	0-	<ol> <li>Race - Ame Black, Whit</li> </ol>	
38	l',or		1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates 195	.6	1 □Yes 2 🛣 No	Specify:			Specify:	White
215-0036	2 hou	Completed by	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Ki	nd of Business	/Industry
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21	d wit gien er the	οπ	12		Balti	more Co.	Police (	Officer	Law	Enforc	ement
Maryland	ould be filed within 72 Mental Hygiene. arked other than "nal attc event, the Medic	Be (	17. Father's Name (First, Middle, Last					me (First, Middle		,	
Уa	should that the stand Men stand Men standarker that the standarker	2	Harry H. Robins				Nora	P. Broo	kmey	er ———	
Jar	2 a is		19a. Informant's Name/Relationship			M					,
	1 and Health em 27 ther to		Shirley Robinso								ryland 21228
altimore,	Pages nent of f int: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Themoval from State	20b. Place of Dispo cemetery, cren		i	Date		cation - City or	rown, State
≣	it. Pa intme intant njury		4 □ Donation 5 □ Other (Special		Meadowri	dge Mem.	Park 2/1	14/2009	E11	kridge,	Maryland
Ba	permit. Pages Department of Important: If its any Injury or o		21. Signature of Funeral Service Lice	Moiliga		. Name and Addre Funeral H	lome of (	eriing A Catonsvi	snto 11e,	Inc.	D WITZKE
			23a. Part 1. Enter the disease, or com	plications that caused the						sville,	MD 21228 Approximate
	Nevaisias	10	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			· · · · · · · · · · · · · · · · · · ·	,	.,,,,,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Coron	ary Arte	ry Diseas	ie				1 day
	Examiner			A-10-1 (100m)	tes Mell	1+10					vears
	ש ב	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co		L.L. M. SJ.					years
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		<b>a</b>		d							7.0
X R Q	death certific e attending p d for use as	<u>√</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		7			1 2	23d. Date of de	livery
n n	deat	sicia	in the past 12 months? 1 ∐Yes 2 ☐ No	4 ☐ Pregnant at tim		Ectopic pregnanc Other <i>(specify)</i>	у			Month	Day Year
О	w requires that the de been signed by the should be detached	Physician/M	9 Unknown								
ń	The law requires that ate has been signed b age 2 should be deta	ğ	Part II. Other significant conditions	contributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.				the cause of death?
0	requi	ted	Htn					147	Yes 2L	_NO 3_P	robably 4 🗌 Unknown
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								1 □Yes	rmed? 2 ☑ No	death? 1 ☐ Yes	2 <b>₫</b> No
=	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		othe Othe	or:	ath (Check only o			
ō	ding Phys n. After this funeral di	5	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien	I 3 LI DOA	4 LI Nursing I	lome 5 A Resi			ecify)
DIVISION	nding th. :: Afte e fune	ertification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Ye	ar) Injury	28c. Injur Work M 1 🗆	(? Yes 2 □ No	200. 20001120	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, codunida	
<u> S</u>	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office	22	28f. Location (	Street and	d Number or R	ural Route Number,
בֿ	rs after al Dir	Cert	4 I Tornicide	building, etc. (c	pecny)			City or To	wri, State)	,	
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Example (Check only one)	nysician: To the best of m niner: On the basis of exa and manner stated	y knowledge, death amination and/or in	n occurred at the tirvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner a place, and due	s stated. e to the cause(s)
	Vithir Comp	Me	29b. Signature and title of certifier	h -		29c. License	e number		29d. Dat	e signed (Mont	h, Day, Year)
	10+		· fr			P51	811		Feb	11,200	09
			30. Name and address of person who Thomas J. Ghior				ad, Cator	nsville,	MD 2	21228	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's	Signature						
	Registra	ar	FEB 19	2000 13	~ A	borked					
DH	1H 17 Rev 1/20	001		,	1 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ÁSTATE OF THAT I ARE TOUS AT THE BROOK OF 12 SAILT AND MENTAL Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Justine Raschka Month <del>Raschka</del> 5:00 P M February 11, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hartland Assit Living Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F Months Days Hours Min. December 29, 1916 Pennsylvania 92 218-05-0837 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Altona Avenue 21122 **IISA** 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Zolman Justine Wunder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Raschka Jr. 104 Altona Avenue, Pasadena, Maryland son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Christ Lutheran Cem. 20a. Method of Disposition 20c. Location - City or Town, State February 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 16, 2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licensee Connelly Funeral Home Of Dundalk, P.A. pullon 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List toly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 semant disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner death certificate be executed and burial-Box 68760. physician the as attending properties for use as Ö the þ ۵. signed b Division of Vital Records, peen has e 2 page After this certificate funeral director, pag or Attending Physician:

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

death

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

ş

Completed

7 is marked other than "natural", or items 23a or 28a-f st traumatic event, I'm Medical Examinar must be notified

is marked other

of Health

permit. Pages
Department of
Important: If It
any injury or o

**Physician** 

. /Medical

Examiner

Pages 1 and 2 should be

Physician/Medical þ Completed Be examiner? Medical Certification: To 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

25. Was case referred to medical

1 Yes 2 No

6 ☐ Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Cusumi

Buxure

WEND

29b. Signature and title of certifier

29c. License number D63726

STE 108

29d. Date signed (Month, Day, Year) 02,12,2009

am

10015

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) かめ プロシャントル 071 4132002 31. Date filed (Month, Day, Year)

32 Registrar's Signature

armo

parke

HUBWAY

State Registrar

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 9:50 PM ames February 4,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice TOWSON
If Under 1 Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 215-86-1305 Months Days Hours Min. Director December 15,1969 Maryland Usual Residence of Decedent 10b. County f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 Tes 2 □ No Director Iti mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? stephens 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify 2 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ite Ma Elementary/Secondary (0-12) College (1-4or 5+) bears lechnician X 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Harr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or R ral Route Number, City or Town, State, Zip Code) Kenneth 3645 lerr. Kaineytriend 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Feb. 14, 2009 21. Six at re of Funeral Service Licensee 22. Name and Address of Facility Howella MD 21207 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Nocar aisseminate Unset and Dear disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed as the burial-trans and resulting in death) Last Box 68760. attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy ō Month Day 5 Other (specify) Ö 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 I Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s has autopsy perform this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) . Manner of Leath 1 D Natural 2 Accident 28b. Time of Certification: After 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending To the Hospius, within 24 hours after death.

To the Funeral Director: Af investigation 1 ☐ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 564 Name and address of person who completed cause of death (Item 23a) (Type, Print) 555-W Towsontown Blud 'VD Dalto

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 04347 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 8014 M KUSSEL HAROLD, RIDGEL 10 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adams Coulty
ocial Security Number Shock Trauma Conter If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 1XM 2□ F **Funeral** Hours Months Days Min Director 219-22-8760 82 MD Dec 19, 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ms 23a or 28a-f short 1 ☐ Yes 2 No Director MD **Baltimore** Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3716 Century Ave Funeral 21227 th and Mental Hygiene.
7 Is marked other than "natural", or items traumatic event, the Medical Extering traumatic event, the Medical Extering traumatic event, the Medical Extering traumatic event, the Medical Extering tra 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No CULL Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 Divorced Specify: White 194 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Ridgely ဂ္ Helen Rebecca Brass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Paula Smith 3602 Cypress St. Corpus Christi, TX 78411 Rughter other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o == Burial 2 Cremation 3 Removal from State ò Department Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Feb 13, 2009 Glen Haven Memorial Park Glen Burnie, MD 21. Signature / Funeral //ice icense 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Softer the discuse, or complications that caused tr shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) troke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burstarnsit mapletely filled in by the funeral director, page 2 should be detached for use as the burstarnsit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 00 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 1285802009 2110109

Registrar
DHMH 17 Rev 1/2001

State

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ALBERT CHI

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eene

Registrar's Signature

S

22

31. Date filed (Month, Day, Year)

			For State Registrar	State of Mary		artment of H Artificate of D		lental Hy	rgiene Reg. No. 20 (	09 04348
	Dhusiai		1. Decedent's Name (First, Middle, Las					2. Date of De	eath Day V	3. Time of Death
	Physicia /Medic		Lewis Robert	Russell				Februa		009  11:35a M
	Examin	er	4a. Facility Name (If not institution, given Transitions Heal			Sykesvi1	Location of Death		4c. County of Carroll	
	Funeral		Social Security Number     6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th say, Year) 9 1925	9. Birthplace (State or Foreign Country)
	Director		216-20-7442 'Usual Residence of Decedent	X M 2□ F   83	Yrs.			July 2	5 1925	MD
	how how	_	10a. State 10b. County	10	c. City, Town or Lo					10d. Inside City Limits
	he Ma 28a-f s	ecto	MD Carroll		Sykesv				10- 02	1 XYes 2 No
	3a or 3	Funeral Director	10e. Street and Number 7309 Second Aven	ue		10f. Zip Code 21784			10g. Citizen of Whi	at Country?
	ems 2	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14. Race -	- American Indian, White, etc.
36	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Error, and to nother a	by Fu	1 Never Married 2 Married 3 W Widowed 4 Divorced	1 □ Wes 2 □ No If Yes, Give Year or Dates:	t.m.tT T	I∐Yes 2X No	Specify:			white
2-00	2 hou	ted	15. Decedent's Ec	lucation		dent's Usual Occupa kind of work done d		ing	16b. Kind of Busin	ness/Industry
121	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I	evision r	)	rig	electron	ics
d 2	filed v Hygie Sther t ent, th	Be Co	17. Father's Name (First, Middle, Last)		1001	CVISION I		e (First, Middle	, Maiden Surname)	
/lan	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the man	To B	Harry P. Russel	1 Sr.			Elsie Met	ZZ		
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	-	19a. Informant's Name/Relationship ( Richard A. Russe			ng Address <i>(Str</i> eet a Harbor Ct			er, City or Town, St	tate, Zip Code)
ത്	tem 27 i		20a. Method of Disposition			sition (Name of natory or other place		Date	20c. Location - Ci	ity or Town, State
altimore,	Pages nent or ant: If i		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State		Park Cem.		-09	Baltimor	e, MD
Balti	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licer	Lerbert		Name and Addres	,	_		e & Chapel
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	Approximate interval Between
1	Physician /Medical		immediate Cause (Final disease or condition resulting in death)	.a	Ponentia					Onset end Death
-/	Examiner			Due to (or as a co	onsequence of):					
Н	pe iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):					
jk	execute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of):					
68760, 💉	icate be executed physician and s the burial-transit	edical E		d						
		Medi	IF FEMALE:							
Box	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Date of Month	•
P.O.	at the de by the tached	hysi	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknown						
Js, I	es tha	þ	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?  Probably 4 Unknown
Records,	w requir s been s should	eted						24a. Was		ere autopsy findings available
Re	: The law cate has t page 2 s	Completed						auto	psy prio	or to completion of cause of ath? □Yes 2□No
Vital	sician: The certificate rector, pag	Be C	25. Was case referred to medicel examiner?				26. Place of Deat			
of \	Physic rthis c ral dire	<u>.</u>	1 ☐ Yes 2 ☐ No 27. Manufer of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier		4 La Nursing Ho		idence 6 Other	
ion	nding Ph ath. r: After thi e funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	ear) Injury	Work	? Yes 2 □No	200. 20001100	now injury occurred	· 
Division	al or Attendi after death. I Director: A d in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	- At home, farm, str Specify)	eet, factory, office		28f. Location ( City or To	Street and Number wn, State)	or Rural Route Number,
Ω	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Director.		29a. Certifier 1 Certifying Pr	ysician: To the best of m	ny knowledge, deat	n occurred at the tin	ne, date and place.	and due to the	cause(s) and man	ner as stated.
	he Hos in 24 h he Fur pletely	Medical	(Check only 2 Medical Exar	niner: On the basis of ex and manner stated	amination and/or in	vestigation, in my op	pinion, death occur	red at the time,	, date and place, an	d due to the cause(s)
6	To the within 2 To the comple	Σ	29b. Signature and title of certifier	' . /		29c. License	number		29d. Date signed (	(Month, Day, Year)
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	1/09 5 Print)	8137		2(11/0	77
			Willey Kus	295 Sto	ne Ar.	e St 30	7 We	Etonens	to n	1021157
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 3 2009	32. Registrar's	Signature .	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 04349 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 10 Physician HARRIET ROSENSWEIG 2009 2:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner HARFORD** UPPER CHESAPEAKE HOSPITAL BEL AIR 8. Date of Birth (Month, Day, Year) 01/31/1949 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 💢 F MD 218-54-0683 60 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No HARFORD BELCAMP Director MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4740 WATER PARK DRIVE, UNIT B 21017 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 72 hours after 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛣 No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) BEAUTICIAN COSMETICS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be file Be MANDEL MARY COHEN MORRIS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. MARC ROSENSWEIG / HUSBAND 4740 WATER PARK DR., UNIT B, BELCAMP, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FORBAND CEMETERY 02/12/2009 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAPH AUREUS **Physician** BACTEREMIA 2 WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISTRESS SYNdrome ACUTE REPORTOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or) the death certificate be executed 21 - FAT 2 PAT 3 M burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No page The Vital certificate 1∐ Yes Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending Injury investigation 1 Tes 2 No 2 Accident death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide ö Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Dav. Year) 120056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSONBIC nbaum, M.D. 500 upper Che Sapea Ke Dr. Bel Air, MD 21014

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

101

February

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Rosenswerg

Registrar's Signature

			for State Registrar	State of Ma	Ce	rtificate of			2009	04350		
	Physici	an	1. Decedent's Name (First, Middle, La.  Margaret E. Sc	•				2. Date of Death Month	Day Year	3. Time of Death		
	/Medic	al	4a. Facility Name (If not institution, giv			4h City Town o	r Location of Death	February	11,2009 4c. County of Death	9:35P M		
1	Examin	ier	Genesis Hamilton			Ba1			lo. County or Double			
	Funeral Director		5. Social Security Number 6. S 217-16-8579		(In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2	Year) 9. Birthr Cour 4,1917 Ma	place (State or Foreign ntry) ryland		
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation			1	10d. Inside City Limits		
	a-f sh	ctor	Md. Bal	to.	Whit	e Marsh		1 □ Yes 2				
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?		
	eath w	Funeral	5528 Edwin Cour	t 12. Was Decedent E	vor in II C 12		1162	posity Voc or No	USA 14. Race - Americ	oon Indian		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanirar must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces?  1 □ Yes 2 ☑ N  if Yes, Give  Year or Dates:	ver iii o.s.	was becedent of F If Yes, specify Cuba 1 □ Yes 21 No	dispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Black, White,			
2-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	(Give	dent's Usual Occup	during most of work	ring 1	6b. Kind of Business/In-	dustry		
121	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+	life.	<i>DO NOT use retired</i> at Wrappe:	d) -		Supermarke	t		
0 0	i filed Il Hygi other ent,	Be Cc	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	laiden Surname)			
<u>/lar</u>	Menta Menta arked attc ev	10 B	Joseph Stadler				Barbara	Zimmerer				
Jar	2 sho n and is ma rauma		19a. Informant's Name/Relationship (		l l	-			City or Town, State, Zip	*		
ė,	1 and Health em 27		Margaret K. Horw	ath DT	,				, Md. 21162			
Baltimore, Maryland 21215-0036	it. Pages rtment of rtant: If It njury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)	20b. Place of Dispo cemetery, cres Gardens of	of Faith	2-16-	2009 В	alto. City	_		
Ba	permi Depa Impo any Ir	5 1	21. Signature of Funeral Service Licer  Bucir Ce U	en	7	9705 B	elair Rd.	Notting	uneral Home ham, Md. 21			
	rificate be executed  Ig physician and as the burial-transit  The burial-transit as the	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirators shock, or heart failure. List only one cause an each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):							Approximate Interval Between Onset and Death			
.O. Box 68	ath cei nttendir or use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. if yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у	<del></del>	23d. Date of delive	ery Day Year		
Records, P.	uires that the de signed by the a ld be detached f	δ	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to the			
O O O	aw requir is been s	Completed						24a. Was an		psy findings available		
ž	Physician: The law this certificate has ral director, page 2 s	mo.						autopsy perform 1 □ Yes 2	ed? death?	mpletion of cause of		
/ita	clan: certific actor,	Be (	25. Was case referred medical examiner?	11		12.		h (Che only one				
o	Attending Physician: It death. ector: After this certifice by the funeral director, p	.T	1 Yes 2 No 27. Manner of eath	Hospital: 1 ☐ Inpatier  28a. Date of Injury	t 2 ER/Outpatier		4 LU-Prorsing Ho	ome 5 Resider	nce 6 Other (Specification)	y)		
o	nding Phith.: After this funeral	ation	1  atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	Year) Injury	Worl	k? Yes 2 □No	EGG. Describe not	v injury occurred			
Division of Vital	al or Attend s after death. I Director: A	Certification: To	3 Suicide 6 Could not be determined	28e. Place of injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	I Route Number,		
	e Hospital or Al 124 hours after o Funeral Direct bletely filled in by	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicai Exam	ysician: To the best of niner: On the basis of and manner stat	examination and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occur	and due to the carred at the time, da	use(s) and manner as s te and place, and due to	tated. the cause(s)		
	To the I	Ž	29b. Signature and title of certifier	1 > 1 - 1 107		29c, Licens	e number	/ () 29	d. Date signed (Month,	Day, Year)		
	W			0 6 7 7 7		100	087	8 7	26 13	2009		
			30. Name and address of person who	completed cause of de		Print) GZA	Cilto	CAL DI	THICHU	1734		
	Sta		31. Date filed (Month, Day, Year)	32. Registra			-01 1	14 1-0	40716	10/7		
	Registr	ar	100	000	6 1	-11						

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 1:10 AM Februrary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR SP TIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **1968** 12/2//<del>2009</del> 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ vF Months Days Hours 220-98-4037 40 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or item any injury or other traumatic event 10b. County 10c. City, Town or Location 10d. Inside City Limits Director **Baltimore** Maryland Halethorpe 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 1935 Bell Avenue United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc.
White 1 Never Married 2 X Married 1 □Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) John Robert Brunner Elsie Lynne Adkins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard F. Seibert - Husband 1935 Bell Avenue, Halethorpe, Maryland, 21227 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial: 2/12/2009 | Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd, Elkridge, Maryland, 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transii resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 

Yes 2 

No 3 

Probably 4 

Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🔼 No 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural ours after death.

neral Director: Al
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ES 000 Feb, 12,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD Hanover s 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			1 - For Amend Item State Registrar		1 Marylan 27,28a-	d / Depa f per Ce	artment of H me, g888, C rtificate of	lealth Death	og M	ental Hyo b	giene2 (	009	04352
	Physici		1. Decedent's Name (First, Middle Robin M. Sm						1	2. Date of Dea Month January	Dav	2009	3. Time of Death  10:50 PM
mark any	/Medic . Examin		4a. Facility Name (If not institution	, give street and nu			4b. City, Town, or	r Location of		January		ty of Death	10.30 F
w ?	, 		Seasons Hospice				Randall					Baltir	
ı	Funeral Director		5. Social Security Number 458 <b>-</b> 94 <b>-</b> 9617	6. Sex 1 □ M 2  F	7. Age (In yrs.	la <i>st birthday)</i> 52 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birtl (Month, Day Feb 21,	1956	9. Birthp Court	place (State or Foreign ptry) DISTRICT Olumbia
	pui *		Usual Residence of Decedent  10a. State 10b. County		100 0	y, Town or Lo							
	Maryla f sho	p	Maryland Balti	more	100. 011	_	isterstow	m					0d. Inside City Limits 1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	INOLO		TIC.	10f. Zip Code	11			10g. Citizen of	What Cour	
	23a c		18618 Insulin I	ane			2113	6			USA		
	er dez	Funeral	11. Marital Status	Armed Fo	edent Ever in U. orces?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Ori an, Mexican	igin? (Spec	cify Yes or No- lican, etc.)	14. Ra Bla	ace - Americ ack, White, e	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Examiner must be notified at	ð	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🎇 Divorced	ed 1 □Yes If Yes, Gi Year or D	ve		1∭XYes 2□No	Specify:	Lati	ino	Speci	ity: Whi	ite
2	72 hou natura	eted	15. Decedent (Specify only highes	s Education		16a. Dece	dent's Usual Occup	ation	t af warkin	g	16b. Kind of E	Business/Inc	dustry
7	vithin sne. than "	Completed	Elementary/Secondary (0-12)	College (	I-4or 5+)	life. I	cinarian	dining mosi ii)	t or working	·	Emoter cons	u Votor	rinary Surgeon
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lar)	2 short and lis ma		19a. Informant's Name/Relationsh			19b. Mailir	g Address (Street	and Numbe	er or Rural	Route Numbe	r, City or Towi	n, State, Zip	Code)
e,	1 and 2 Health em 27 i		Cathleen Richar 20a. Method of Disposition	cdson, Si		6021	CR 1023	<u>Joshu</u>	a, TX		200 Lasatian	O:4 T-	
JOE L	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from			sition (Name of natory or other place ematory I				20c. Location	•	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. once.		21. Signature of Funeral Service k	licensee	Tice	22 ماري 10 ماري	Name and Address	of Facility	A** UE	Mozavil.	Daltin	nore,	Maryland
<u> </u>	8 9 E 8 8	6 4	Inomas Grego		20.50	25	Name and Address emation 9 Freder	ick R	oad B	Baltimo:	and, Ir <u>re, M</u> ar	nc. cyland	1 21228
	200	15 0	23a. Part 1. Enter the disease, or shock, or heart failure. List of	only one cause on e	ach line.	h. Do not ent	er the mode of dyin	ig, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	DOXIC		Injury						
	Examiner		Due to (or as a consequence of):  Klonipin Overdose  b.										
	ed sit	iner	Sequentially list conditions, and any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Klonipin Overdose  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  CERTIFICATION APPROVED BY MEDICAL EXAMINER  C. Due to (or as a consequence of):										
	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c	or as a consequ	uence of):		Do	ON APPRO	ED BY MEDICA			
8760,	cate be executed physician and the burial-transit	dical		d				CER IFICAL	101.				
9	ertifica ling ph e as th	Med	IF FEMALE:	<u> </u>									
Box	leath certific attending p for use as	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna birth 2□Feta nant at time of d	Ideath 3 ☐	Ectopic pregnancy Other (specify)	,				ate of delive	ery Day Year
<u>Р</u> О	w requires that the dispension is been signed by the should be detached	Physician/Me	1 □Yes 2 □√Ño 9 □ Unknown	9 □ Unkr		icaii J	Tottler (specify)						
	res tha signed be der	þ	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the ur	nderlying cause give	en in Part I.				ntribute to th	ne cause of death?
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	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Completed		<del> </del>						24a. Was a autops perfori	med?	prior to con death?	psy findings available npletion of cause of
Vita	ian: T	Be C	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only on			2 🗆 No
> 5	hysic this ce al dire	ည	examiner? 1 Yes 2 110		Inpatient 2			er: 4□ Nu	rsing Hom	e 5 ☐ Reside	ence 6 Ot	in filth ther (Specify	vent hospice -
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Division of	Atten er deal ector: by the	Certification:	3 Suicide 6 Could na 4 Homicide determin				eet, factory, office	103 24			_		
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification in the funeral director, the funeral director director, the funeral director director directors direc	ledical	29a. Certifier 1 Certifying (Check only one)	Physician: To the xaminer: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or in	occurred at the tire vestigation, in my o	ne, date an pinion, dea	id place, ar th occurred	nd due to the o	ause(s) and n late and place	nanner as st , and due to	tated. the cause(s)
	o vitt	Σ	29b. Signature and title of certifier  **NSCaraptime**	900			29c. License		<i>C</i>	2	9d. Date signe	ed (Month, L 17/09	Day, Year)
			30. Name and address of person v	U	se of death (Item	1 23a) (Type		5746			1/ {	. 1109	
			N.5 Kajapaksei	MD, 25 MG	in St. Su	ite 200	Print) Reisterstz	own, 1	MD.	21136			
	Sta Registra		31. Date filed (Month, Day, Year) - FEB 1 2 20	JP. 19	egistrar's Signa	ture							
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State of Maryland / Department of Health and Mental Hygiene 04353 Reg. No 20 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** STEPA NOFF FEB 9, 2058 /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park
If Under 1 Year | If Under 24 Hrs. Montgomery Washington Adventist Hospital (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Days Hours Min 90 040-09-4834 Director MAY 15, 1918 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits is 23a or 28a-f show 1X Yes 2 □ No Director Washington, DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20012 7416 7th St., NW Funeral marked other than "natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No 2 Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banquet Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Cica Salvatore Bove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 437 Butternut St. NW., Washington, DC permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. Richard Cambosos/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2/12/2009 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Cremation Services Ma0382 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerche heart dizease /Medical Examiner ONACH WEART Generalisms to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Multiple Syskin Diger Failure Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 ☐ Other (specify) has been signed by the e 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this continue funeral dire 1€Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director; / 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68068 Physcian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave., Takoma Park, MD MD Craig Dates, 31. Date filed (Month-Day, -Year) 32. Redistrac's Signature State Registrar

ype or Print in Black Indelible III. Lines American State of Mary and Fee American State of Death Reg. No. 2009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stevens DANiel 2009 31:36 me -6 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MediCALC -imo Re enter altimoRe 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Hours Min Director -14-9569 84 Jan 5 1925 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Talbot Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3040 Jamaica Point Rd. 21673 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 XIYes 2 No
If Yes, Give
Year or Dates: WWI Z 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than **Truck Drive** 12 Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Harry Stevens မ Tillie Daniels 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 27 Durelle M. Stevens Spouse other t 3040 Jamaica Point Rd. Trappe, MD 21673 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 11, 2009 lvy Hill Cemetery Philadelphia, PA 21. Signature of Funeral Service Lie 22. Name and Address of Facility Urban Funeral Home, Inc 1111 S. Bethelem Pike Ambler, PA 19002 MO0535 art 1. Enter the diseare, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failing. List only one cause are a hine. Approximate Interval Between Onset and Death ediate Cause (Final Immediate Gause (1) Is ease or condition resulting in death) Physician neumonta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) s been signed by the s 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 □ Yes 2 🗆 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 ☐ Yes 2 ☐ DNO 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 ☐ Matural 2 ☐ Accident 5 Pending investigation 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) FEB 1 3 2009

Ceyno

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

316106206

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	•		cate of L		F	Reg. No. 2	009	04355	
	Physicia	n	1. Decedent's Name (First, Middle, Last						2. Date of Dea Month	Day	Year	3. Time of Death	
	/Medic	al -	4a. Facility Name (If not institution, give	Adele S	impier	4h	City Town or	Location of Death	F	eb 7, 20	nty of Death	10:50 P <sup>M</sup>	
	Examin	er		in Avenue		40.	City, lowil, or	Catonsville		10. 000	Baltimore		
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birth		Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	h v, Year)	9. Birth	olace (State or Foreign	
	Director		10,00,000	] M 2 M F	92 Y	rs.	Days	110410		25, 1916		MD	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	า					I0d. Inside City Limits	
	Maryi f sho	to	MD Balt	imore				Catonsville				1 □ Yes 2 No	
	h the	Director	10e. Street and Number			10	f. Zip Code			10g. Citizen	of What Cou	ntry?	
	23a c	ral	33 Melvin Ave.					21228		44.5	U.S		
	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show soical Ezercines must be nutified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 N	ver in U.S.		1	ispanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	14. F	Race - Ameri Black, White,		
ا ا	al", or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Y	es 2 📉 No	Specify:		Spe	ecify: Wh	nite	
9500-¢1	72 hou	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a.	Decedent's (Give kind	Usual Occupa	ation during most of worki	ng	16b. Kind of	f Business/In	dustry	
7	filed within 72 Hygiene. other than "nai	mpk	Elementary/Secondary (0-12)	College (1-4or 5	+)	`life. DO N	OT use retired				Ref	hail	
N	be filed watal Hygie	e Co	17. Father's Name (First, Middle, Last)	2_				Retail 18. Mother's Name	(First, Middle,	Maiden Surr		lan	
⊆	be od c	To Be	, , , , , ,	James Pr	att				H	lelen Ph	illips		
ary	2 should and Mer is marke aumatic	٦	19a. Informant's Name/Relationship (7	ype. Print)	19b.	Mailing Ac	dress (Street	and Number or Run	al Route Numbe	er, City or To	wn, State, Zi	p Code)	
	ges 1 and 2 should nt of Health and Mer If item 27 is marke or other traumatic		L. Coard Simpler So	1				Baltimore, M	D 21230	On Leastin	on - City or T	ours State	
Baltimore,	Pages 1 nent of H unt: If itel ury or otl		20a. Method of Disposition 1 Burial 2 Cremation 3 D	Removal from State	20b. Place of cemetery	y, cremator	y or other plac	i					
	permit. Page Department Important: If eny Injury o		4 □ Donation 5 □ Other (Specify  21. Signal registers of Funeral States of Funeral	-	All Cou	-	mation Ser		11, 2009	S	ykesville	e, Maryland	
g	Department Department			11 Show	HUDLIGE	3		ineral Home, P d Columbia Pil	P.A. Ge Ellicott (	City. MD 2	1043		
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	uted d ansit	Examiner	frank teaching to francolate cause. Enter Underlying Cause (Disease or injury that initiated events										
ó	tificate be executed g physician and as the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequence o	of):	*						
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P.O. Box	death atter	Physician/N	23b. Was decedent pregnant in the past 12 pronths?	4 Pregnant at	2  Fetal death time of death		opic pregnanc ner (specify) _	У			Month	Day Year	
Ö	at the de by the tached	hys	9 🗆 Unknown	9 🗌 Unknown	-4							and the control of th	
S,	res tha	by F	Part II. Other significant conditions of				ying cause giv	en in Part I.		obacco use o Yes 2 ☑ N		the cause of death?	
oro	w require s been stand	eted	Coronery a		reare				24a. Was			opsy findings available	
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Vital Records,	an: Th tificate or, pa		25. Was case referred to medical					26. Place of Deat	1 □ Yes h (Check only o		1 ∐ Yes	2 □ No	
Ž	Physician: The law this certificate has al director, page 2 a	lo Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatient 3	DOA Oth	er: 4 🗆 Nursing Ho	ome 5 Resi	dence 6	Other (Spec	sify)	
0	Attending Physician: The law requires that the death cer riceath. ector: After this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use	ü.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of njury	28c. Injur Wor	K?	28d. Describe	how injury oc	curred		
Division of	ttend death. stor: / / the f	icat	2 Accident investigation 3 Suicide 6 Could not be		ury - At home, fai			Yes 2 □No	28f. Location (	Street and N	umber or Ru	ral Route Number,	
<u>≥</u>		Certification: To	4 Homicide determined	building, et	c. (Specify)				City or To	wn, State)			
	• Hospital or Attending Ph 24 hours after death. • Funeral Director: After th etely filled in by the funeral		(Check only 2 Medical Exan	ysician: To the best niner: On the basis o	f examination an	e, death oc id/or invest	curred at the ti igation, in my o	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)	
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in I	Medical	29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	se number		29d. Date si	igned (Month	, Day, Year)	
	->-0		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	CM			Doc	504703		03	, 09	, 2009	
	8		30. Name and address of person who	completed course of d	leath (Item 23a)	(Type, Prin	+\						
			31. Date filed (Month, Day, Year)	6565 No	ar's Signature	s de c	24. 5	orte 20	3 Rec	HI MON	e MI)	21204	
	Sta Regist		FEB 1 3 2009	65G5 No	B. A	rack							

			State of Maryland / De			Mental Hygie	ene	
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of	Death	Reg	1. No. 200	9 04356
	Physicia /Medic		John Barnes Seward			Feb 9	Day 200 9 ar	
	Examin	er	4a. Facility Name (If not institution, give street and number)		or Location of Death	)	4c. County of Dea Baltim	
-0	Funeral		1900 Grove Manor Drive  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Essex  If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	rthplace (State or Foreign
	Director		218-34-7717 1□XM 2□F 70 Yrs	Months Days	Hours Min.	Dec 5,1	<sup>6</sup> 938	ountry) MD
	and ww		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	Maryl	tor	MD Baltimore E	ssex				1 ∐Yes 2. No
	h the	irec	10e. Street and Number	10f. Zip Code		100	g. Citizen of What C	ountry?
	ath wil	ral	1900 Grove Manor Drive		21221		USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan har must be notified at ODCE.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of Hard If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Ye's or No- o Rican, etc.)	14. Race - Am Black, Whi	te, etc.
5-0	72 hou	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupive kind of work done	pation during most of work	kina 1	6b. Kind of Business	s/Industry
21215-0036	within sne.	Completed by	life	e. DO NOT use retire ales	d)		Floori	ng
d 2	filed v Hygir other	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Ma	niden Surname)	
/Jan	Venta Venta	To B	Vernon William Seward		S. V.	irginia	Barnes	
Maryland	nd 2 sho lith and 1 27 is ma r trauma	i		ailing Address (Street Allwood			•	
re,	of Hear		20a. Method of Disposition 20b. Place of Disposition	sposition (Name of rematory or other place w Cremat	ce)	Date 20	c. Location - City or	r Town, State
altimore,	Page ment ant: If		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	w Cremat	ory 2	0 09 E	Baltimor	e MD
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licensee	22. Name and Addre	31		Ave. Ba ne of Es	lto. MD sex 21221
0	Physician <sup>®</sup>		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each live.  Immediate Cause (Final disease or condition	enter the mode of dyi		or respiratory arres	et,	Approximate Interval Between Onset and Death
A. S. C.	/Medical Examiner		resulting in death)  Due to (or as a supsequence of):	NOISNE	)	,		
	D .tt	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					4/04
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):				7 10-1	
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	rtificat ng phy as the	fedic	U					
O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely illied in by the funeral director, page 2 should be detached for use as	Physician/Me		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of delivery Month Day Year	
Records, P.	uires that the de signed by the d be detached to	by	Part II. Ather significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba		to the cause of death?
000	sw require s been si should b	Completed	ALCOLDO LISM			24a. Was an	24b. Were a	utopsy findings available
<u></u>	The law ate has page 2 s	mo	MITRAL VALVE DEDA	HR		autopsy performe 1 ∐Yes <b>3</b>	ed? death?	completion of cause of
Vita	cian: ertific	Be C	25. Was case referred to medical examiner?			th (Check only one)		
<del>_</del>	Physi this c		1	HEIN 3 DOA			ce 6 Other (Sp.	ecify)
o	ding th. After funer	tion	1 Natural 5 Pending (Month, Day, Year) Injur	y Wor	rk? ]Yes 2∐No	28d. Describe how	injury occurred	
S Division of	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	Bural Route Number,
(h	he Hospit in 24 hour he Funera pletely fille	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, do not be desired in the desired form of t	ath occurred at the ti	ime, date and place opinion, death occu	e, and due to the cau irred at the time, dat	use(s) and manner a e and place, and du	as stated. le to the cause(s)
	To t To t	M	29b. Signature and title of certifier  What War War	29c. Licens	y 80 2	290	d. Date signed (Mon	2009
			30. Name and address of person who complete dause of death (Item 23a) (Type 100) (Type 1	e, Print) 22C	1 Clips	3/80 A	me, R	1237
i,	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	4.1				

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2009 26 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner omewood more 7. Age (In yrs. last birthday) If Under 5. Social Security Number Birthplace (State or Foreign **Funeral** Year) Months Davs Hours Min. 1**5** M 2□ F 58 578-66-2320 D.C. 3-4-1950 Wash Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or tems 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 THYES 2 □ No fimore Director Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 🔽 If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) todian 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon 2020 llo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 16.2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice de 1701 Mc Culla 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one caust at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Obyh if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed reson burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ pe 2 No 3 Probably 4 Hinknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed' certificate 2 1 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Aursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

300 BALTIMORE MD 2/2/64

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1+A31+m1

1 3 2009

31. Date filed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registra

(Check only one)

STANLEY M.

29b. Signature and title of certifier

KMAN

H41069

29c. License number

2000

29d. Date signed (Month, Day, Year)

11:25 P M

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

3 Probably 4 Unknown

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1308 BUSINESS CENTER WAY

EDGEWOOD, MD.

32. Registrar's Signature 31. Date filed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 10 2009 **Physician** 10:45 A M SEIDMAN SIGMUND SHERALD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE MANOR CARE OF RUXTON TOWSON If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
MD 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 X M 2 ☐ F **Funeral** Months 05/01/1931 77 213-28-2373 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 □Yes 2 No REISTERSTOWN BALTIMORE MDDirector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 GLYNN GARTH 21136 USA Funeral 13. Was Decedent of Hispanic Orlgin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 11. Marital Status 1 Never Married 2 Married WHITE 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SEIDMAN GLASS COMPANY OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filk ment of Health and Mental Hisant: If Item 27 is marked oth Be **JESS** DUNCAN SEIDMAN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOANNE SEIDMAN / WIFE 4313 BEDROCK CIRCLE, APT. 102, NOTTINGHAM, MD 21236 20b. Place of Disposition (Name of MI RRO er KODESH other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of HIMPortant; If Ite 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH ISRAEL CONG. 02/12/2009 | BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral a rvice Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of: Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Month Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 2 No certificate 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 [ Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

FER13

DHMH 17 Rev 1/2001

PPE 209 Balto Wd Zizo4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Engistrar's Signature

			For Sta	ate of Maryland / D	epartment of F	Health and Me Death		ne No. 2009	04360
			Negistrar  1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medio			Smith	1		ebruar	<sup>Day</sup> 8,2009	
	Examir	er	4a. Facility Name (If not institution, give street Riverview Care Ce		4b. City, Town, o	r Location of Death		4c. County of Death Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 17 - 16 - 4629	7. Age (In yrs. last birti	hday) If Under 1 Year Months Days	Hours Min.	Date of Birth Month Day, Ye Dec 29, 1	9. Birth 923 Mar	place (State or Foreign ntry) yland
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	he Mar 28a-f sl	ector	Md. Baltimore	<u>Dund</u>			100	Citizen of What Cou	1 ☐ Yes 2 No
	h with t	al Dir	10e. Street and Number  101 Center Place		10f. Zip Code 2122	22	Tog.	U.S.A.	nuyr
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event har must be notified at once.	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? ∐Yes 2 <b>X N</b> o Yes, Give ear or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
5-00	72 hou 'natura dical E	Completed by	15. Decedent's Education (Specify only highest grade com	16a.	Decedent's Usual Occup (Give kind of work done	during most of working	16t	o. Kind of Business/Ir	
2121	within piene. r than "	ompl	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	Home Make	d)		Own Hom	e
Baltimore, Maryland 21215-0036	uld be filed Mental Hyg arked other affc event, l	To Be C	17. Father's Name (First, Middle, Last) Michael Kwiatkows	ski		18. Mother's Name (	First, Middle, Maid	den Surname) (U	nk)
, Mar	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (Type. P Mary Kerns (Daugh	nter) 26	Mailing Address (Street 11 Libert	y Parkway	Balti	more, Md	. 21222
nore	ages 1 ent of H t: If iten y or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Remov		Disposition (Name of y, crematory or other place n Park	Da (2 - 11 -		. Location - City or T 1 t imore.	own, State Maryland
Baltin	permit. P Departme Importan any Injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Loudo	22. Name and Addre	ss of Facility Kacz	zorowsk	i Funera	1 Home,P. Md. 21222
	Physician		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car Immediate Cause (Final disease or condition	ns that caused the death. Do nuse on each line.	ot enter the mode of dying	ng, such as cardiac or	respiratory arrest,	,	Approximate Interval Between Onset and Death UM - HWM
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):				
	ted sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	f):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a consequence o	ή:				
Вох 68	leath certificat attending phy for use as the	n/Medi		yes, outcome of pregnancy				23d. Date of deliv	/ery
P.O. B	that the death ned by the atter detached for	Physician/Me	in the past 12 months?	☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death ☐ Unknown	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	čy		Month	Day Year
	signed be det	by	Part II. Other significant conditions contribu	ing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	. /
of Vital Records,	law requir as been s 2 should	Completed	Seizure dis	order.			24a. Was an	24b. Were aut	opsy findings available
al Re	siclan: The lav certificate has rector, page 2 y	Com	0				autopsy performed 1 □ Yes 2 <b>X</b>	d?   death?	ompletion of cause of 2 □ No
Vita	Physiclan: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	al: 1 ☐ Inpatient 2 ☐ ER/Out	tratient 3 DOA Oth	26. Place of Death		e 6 □Other (Spec	(6.)
	nding Phys tth. : After this e funeral dii	ation: To		a. Date of injury 28b. T	ime of 28c. Injury Wor		Bd. Describe how i		iry)
Division	al or Atters after des l'Director din by the	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28	3f. Location (Stree City or Town, S	t and Number or Rui tate)	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	(Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and and manner stated.					
	To the viething comments of the comments of th	M	29b. Signature and title of certifier M	D	29c. Licens	e number 8754		Date signed (Month) bruary 9	
1	) v		30. Name and address of person who comple Dr. Malika F. Was	ted cause of death (Item 23a) (eem, M.D. 70		Blvd. Ba	altimor	e, Marvl	and21221
	Sta		31. Date filed (Month, 'Day, Year)-	32. Pegistrar's Signature				, <b>,</b> -	
DH	Registr MH 17 Rev 1/2	-	FEB 1 3 2009	Daws B.	faces				
				C	RIGINAL				

			1 - For State Registrar	State of Ma	aryland		artment o			Mental H	ygiene Reg. No.	1009	04361
П	Physici	an	Decedent's Name (First, Middle, Last							2. Date of D	Death Day	Year	3. Time of Death
	/Media		Leroy Wardell T								5,20	09	9:00 A
1	Examir	ier	4a. Facility Name (If not institution, give				4b. City, Tov			ath		County of Deat	h
-			Bluepoint Nursi 5. Social Security Number 6. Se		e (In yrs. las	t hirthday)	Balti    Under 1 Y		= Under 24 Hr	s. 8. Date of 8			halana (State or Foreign
	Funeral Director		,	∄M 2□F	94	Yrs.			ours Mir	n. (Month, E	Day, Year)	Co	hplace (State or Foreign untry)
	יסי		Usual Residence of Decedent							Sept	. 21	, 1914	VA
	nylan show	<u>.</u>	10a. State 10b. County		10c. City, T								10d. Inside City Limits
	8a-1 s	cto	Maryland N/A	Ą	Ba	ltin							1 X Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show yth; I'le Medical Examiner must be notilled at	Completed by Funeral Director	10e. Street and Number	700110			10f. Zip Co 212					zen ol What Co USA	untry?
	ss 23	era	502 Sheridan Av	12. Was Decedent f	Ever in II S	12.1			nio Origin? /	Specify Ves or A		14. Race - Ame	door ladie.
<b>,</b>	tter d	Ē	1. Never Married 2 Married	Armed Forces?		13.1	f Yes, specify	Cuban, M	lexican, Pue	Specify Yes or Norto Rican, etc.)	1	Black, White	e, etc.
8	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		,	1 ☐ Yes 2 🔀	No St	pecify:			SpecifyBla	ck
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2	han "	mpie	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work d DO NOT use r	etired)	goo. o,	g	Can	i+>+io	n Truck
2	lied v tygie thar ti		6th grade 17. Father's Name (First, Middle, Last)			Help	ber	10	Mother's No	ame (First, Middi			II IIUCK
and	d be f	Be	Andrew Taylor						Mary	ame ( <i>FII</i> SI, MIOOI	e, <i>Maide</i> n	Sumame)	
<u> </u>	should mark mark	ဥ	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailin	ng Address (St			Rural Route Num	her City o	Town State 2	in Codel
Š	nd 2 ith ar		Denise Butler/		iece	502	Sheri	dan	Aven	ue Bal	timo	re,Mar	yland
re,	of Heal	1	205 Method of Disposition		20b. Plac	e of Dispo	sition (Name o	of r niace)	2/1	Date		cation - City or	
Ë	Page nent c int: If iry or		1 □xBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	Mt.	Car	sition (Name of natory or other CMEL C	Cemet	te <b>f</b> ý'	2/09	Dun	dalk,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depenment of Heatth and Mental Hygiene. Depenment of Heatth and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at ance.	Ì	21. Signature of Funeral Service Licens	ee X/	•	22	. Name and A	ddress of	Facility("h	atman-	Harr	is Fun	eal Home
_	90 E = 9		Deray	1/61	No	52	240 Re	eiste	ersto	wn Rd	Balt	imore,	Md 21215
			23a. Part1. Enter the disease, or compleshock of heart failure. List only of	ications that caused ne cause on each lin	the death. (	Do not ente	er the mode of	dying, su	ich as cardia	ac or respiratory	arrest,		Approximate Interval Between
	Physician	7	Immediate Cause (Final disease or condition resulting in death)	Che	me	e-6	Holl	لب	سع	- tull	July 1	ease	Onset and Death
	/Medical Examiner		1	Due to (or as a	consequen	nce of):							
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	d d ansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
ó	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequen	ice of):							
8760,	cate be executed physicien and the burial-transit	Physician/Medical		d									
<u> </u>	entific ling p	Mec	IF FEMALE:	-									
Вох	attence for us	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth	2 ☐ Fetal de	ath 3	Ectopic pregn				2	3d. Date of deli- Month	very Day Year
О	the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time oi deatr	n 5_	Other (specif	у)					
σ.	The law requires that the death certific is has been signed by the attending page 2 should be detached for use as		Part II. Dther significant conditions con	ntributing to death bu	t not resultin	ng in the ur	nderlying cause	e given in	Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
Division of Vital Records,	quires in sign	ed by								1 🗆	Yes 2	No 3□Pro	obably 4 Unknown
ဝ္တ	law reas bee	piet								24a. Wa		24b. Were au	topsy findings available ompletion of cause of
~	The lay ate has page 2	Completed								auto peri 1 🗆 Yes	ormed?	prior to c death? 1 \( \sum \text{Yes}	ompletion of cause of
ita ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26.	Place of De	eath (Check only	_	10.00	27.10
<u>~</u>	hysio this co at dire	ဥ	1 ☐ Yes V No	lospital: 1   Inpatier		/Outpatient			Nursing	Home 5 ☐ Res	idence 6	□Other (Spec	ıfy)
Ĕ	ding P	o u	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28	b. Time of Injury		Injury at Work?		28d. Describe	how injury	occurred	
Sic	or Attending Physician: after death. Director: After this certifica in by the funeral director.	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ny - At home	larm etro		1 Tes	2 🗆 No	28f. Location	(Stroat no	Number or Bu	ral Route Number,
≧	after Direct d in by	Certification:	4 Homicide determined	building, etc	(Specify)	, 14111, 3(16	sec, ractory, on	ille		City or To	wn, State)	rvaniber or ru	ar noute wattiber,
	ospite hours unere ly fille		29a. Certifier 1 Certifying Physical Control of the	sician: To the best o	f my knowle	dge, death	occurred at th	ne time, da	ate and plac	e, and due to the	cause(s)	and manner as	stated.
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examin	and manner state	ted.	and/or inv	4			curred at the time			
	o d vit		29b. Signature and title of certifier	BI	el.	٠, ٠	29c. Lic	cense num	noer	an	29d. Date	signed (Month	
A	į		House	moloted asset of	ash (trans	- V		y Z	-16	00	2	16/3	2009
1	V	'	30. Name and address of person who co	impleted cause of de		oa) (Type, I	-iinty	18.0	SUC	_ ~	2/2	15	
Ĭ	Sta		31. Date liled (Morlin, Day, Year)	32. Pegistra				- 4 H				<u> </u>	
	Registr	ar	FEB 1 3 200	19 Lamer	w D.	. 100	exhal						

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 21:46PM February Donna R. Toelle 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAtimore St Agnas Haspital\_ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) 5. Social Security Number Funeral Months Days Hours Min 1 □ M 2 🖼 F Yrs. 218-32-4965 Director Dec. 16, Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene important; or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho ampirity or other traumatic event; It is Invalid at an once. 1 ☐ Yes 2 🖾 No Catonsville Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 330 Wessling Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname)
Anna Margarite Burry 17. Father's Name (First, Middle, Last) Be Lloyd Otis Robertson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Milton Toelle Husband 330 Wessling Circle; Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem.Garden 2/17/2009 Marriottsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Sovice 1630 Edmondson Avenue: Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cordiomy o partu **Physician** ische mie P 00 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner signed by the aftending physician and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☑ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Benjaguane, ont February, 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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Barker

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32 Registrar's Signature

Bentuouan

2 2000

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No.2009 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Frisselle C. Timbers FEB. 10,2009 6:40 A-M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Levindale Hebrew Geriatric Ctr. and Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 92 Yrs. 8. Date of Birth (Month, Day, Year) 4–15–1916 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 ☐ M 2 🗓 F 579-24-3928 VA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Randallstown MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8504 Valley Hill Court 21133 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: African-American 3altimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Damestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Watkins Fountain Clarke 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun onc. Carl A. Timbers/Husband 8504 Valley Hill Court, Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 K Burial 2 □ Cremation 3 □ Removal from State LakeView memorial 2-14-09 Eldersburg, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wile Funeral Home F.A. of Batto. Go. 21. Signal re of Funeral Service Licensee 9200 LibertyRoad, Randallstown, MD 21133 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NONISCHEMIC CARDIOMYOPATHY **Physician** /Medical Due to (or as a consequence of): HEMORRHAGE Examiner SUBARACHNOID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by RESPIRATORY FAILURE 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown icate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

P.O. Box 68760 Division or Vital Records, Hospital or Attending Physician: n 24 hours after death.

e Funeral Director: Af bletely filled in by the fun filled in by To the Hosp within 24 hou To the Fune completely fi

> State Registrar

31. Date filed (Month, Day, Year)

thing H- WILDEHIWOT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

(Check only

2434 W, BELVEDERE, AVE. BALTIMORE, MD 21215 GIZAW WOLDEHIWOT, MD 32. Registrar's Signature

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

10063327

29d. Date signed (Month, Day, Year)

FEB. 10, 2009

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	Ex	amine	
Division of Vital Records, P.O. Box 68760, 🛪	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 nours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

	T = For State Registrar	Otate of Wary		epartment of F Certificate of			eg. No. 2 0 0 9	04364
Physician	1. Decedent's Name (First, Middle, L	ALD IVIA				2. Date of Dear Month		
/Medical Examiner				4b. City, Town, o	r Location of Deat		4c. County of De.	
	UNIVERSITY OF A				LTIMORI			
Funeral Director		Sex 7. Age (In	73 Y	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 8,	1935 Mai	rthplace (State or Foreign Country) Cyland
/land	10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
r 28a-f show	Pennsylvania York		Fawn Go	ove				1 ∐Yes 2 <b>x</b> No
h with the Mar 23a or 28a-f s st be notified	10e. Street and Number 443 Throne Rd.			10f. Zip Code 17321		1	0g. Citizen of What C	country?
filed within 72 hours after death with the Maryland Hygiene. Hygiene. other than "natural", or items 23a or 28a-f show ent, the Modical Examiner must be notified at e. Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of Hif Yes, specify Cub. 1 □ Yes 2 ☒ No		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: W	te, etc.
be filed within 72 hou tal Hygiene. d other than "natura event, the Medical E	15. Decedent's E (Specify only highest g.			Decedent's Usual Occup Give kind of work done life. DO NOT use retire Ocant Master	oation during most of wor d)	king	16b. Kind of Busines	ŕ
Hygier then the nt, inc.	17. Father's Name (First, Middle, Las	.41	561	geant rester	19 Mothor's Non	ne (First, Middle, I		-
Mental I arked of attic eve					Dorothy L.		valueri Surriame)	
and 2 shou saith and M	19a. Informant's Name/Relationship Joan Gloria Valdivia			Mailing Address (Street Throne Rd. F			r, City or Town, State,	Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, tru Modical Exagnes.  To Be Completed by	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control o	☐ Removal from State	20b. Place of Decembery, Lake Vie	Disposition (Name of crematory or other place W. Mem. Park	<sup>ce)</sup> 2/13,		20c. Location - City o	
permit. Departi Import any inj	21. Signature of Funderal Service Lice	ensee Salas	161)	22. Name and Addre Evans Funera 8800 Harford	ss of Facility I Chapel & Road, Pari	Cremation Wille, Mar	Services - F yland 21234	arkville
Physician	23a. Part I. Enfer the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	inplications that caused the yone cause on each line.						Approximate Interval Between Onset and Death
/Medical Examiner	Conventially liet conditions	Due to (or as a co		ogenous	leuk	emia		
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tificate be executed g physician and as the burial-transit	resulting in death) Last	Due to (or as a co	nsequence of)	): 				_
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To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒No	23c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey		23d. Date of do Month	elivery Day Year
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stcian: The law requirector, page 2 should						24a. Was a autops perforr 1 □Yes	ned? prior to death?	utopsy findings available completion of cause of s 2 \( \sum \) No
slciar certif irector	examiner?	Hospital:	0 ED/0	eatient 3 DOA Oth	or.	th (Check only on		
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tal or Attending P rs after death. al Director: After i led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not 1 4 ☐ Homicide determined		At home, farm Specify)	n, street, factory, office		28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
o the Hospit ithin 24 hour o the Funer ompletely fill Medical		Physician: To the best of mainer: On the basis of examiner stated.	amination and/	death occurred at the ti or investigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
12+1	29b. Signature and title of certifier	- SHms	*	29c. Licens	2293		9d. Date signed (Mor	
	30. Name and address of person who VICTORIA SIFFI,	MD 22 S	S. GRE	(pe, Print)  EENE ST.	BALTI	MORE,	MD 215	201
State Registrar	31. Date filed (Month, Day Year)	32. Registrar's S	Signature	Sperked		•		

			For State	State of Marylan				Mental Hyg	iene 2009	04365
_	_		Registrar  1. Decedent's Name (First, Middle, Las	*)	Ce.	rtificate of	Deam	2. Date of Deat	eg. No.	3. Time of Death
	Physici		GRACE F	REATPIC		VAN	CE	Month	Day Year	9:30 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	Februm	4c. County of Deat	
	LXaiiiii	C1	HARBOR	HOSPITA		BA	LTIM	IORE	N/A	
	Funeral		5. Social Security Number 6. Se	_ 1/		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		219 80 1668 "	лм 2 <sup>М</sup> ғ	Yrs.			. (Month, Day, 07/29/	1924   Mai	ryland
	land ow		10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	Man,	ţċ	Maryland Anne A	rundel (	Glen B	urnie				1 ☐ Yes 2X No
	th the	Director	10e. Street and Number		_	10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath wi	ral	403 West Ornance				1061		U.S.A.	
	items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No	S. 13.	Was Decedent of F If Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
DS D	urs af	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:		Specify: W	nite
15-003b	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ication	16a. Dece	dent's Usual Occup	pation	orkina	16b. Kind of Business/	
7	/ithin ine. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	d)		Own Home	
V	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the Washington I show the I had a so to 23a or 23a-f show ent, the Madical Evaminar must be notified at		12th 17. Father's Name (First, Middle, Last)		ноп	nemaker	18. Mother's Na	ıme (First, Middle, M		
yıand	should be nd Mental marked o	To Be		William Benton	Cushw	<i>r</i> a		rgaret A.	ŕ	
	shou and M s mar	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route Number	, City or Town, State, 2	(ip Code)
, <u>Z</u>	1 and 2 Health a em 27 is	,	Carol Hall / Dau			Long Poi		Pasader	na, Marylan	d 21122
	Pages 1 and 2 should be filed within 72 hours after death with the Marylan neart of Heath and Mental Hygiene. Int: If then 27 is marked other than "natural", or items 23a or 28a-f show int: If the 27 is marked other than "natural", or other traumatic event, the Macinal Examinar must be notified at	М	20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 3 ☐	20b. P	lace of Dispo emetery, crei	osition (Name of matory or other pla			20c. Location - City or	
	t. Pag rtmen rtant:		4 □ Donation 5 □ Other (Specify	Bay		Crematory			Baltimore,	
מ מ	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service kicking	2		2. Name and Addre	G	once Fune	ral Service	e, P.A. yland 21225
	_		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death						Approximate Interval Between
	Physician	0.1	Immediate Cause (Final	11 7 +	5	20.1		CONTRACTOR NAME		Onset and Death
	/Medical		disease or condition resulting in death)	a. Due t (or as a consequ	uence of):	TURE	ro scle	10217		3 hours
	Examiner		Sequentially list conditions.	b						
CV	led isit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dile to (or as a consequ	ience of):					
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Š Q	ath ce ttendii or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3[	☐ Ectopic pregnand	су		23d. Date of del Month	
5	the a	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	eath 5[	Other (specify) _			Month	Day Year
7	that the	Ph	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
SD	tuires n sign lid be	d by						1 □ Y€	es 2 No 3 Pr	obably 4 🔀 Unknown
ecords	s beer	Completed						24a. Was a	n 24b. Were au	topsy findings available
Ë	The la ite ha	omp	-					autops perforr	ned?   death?	completion of cause of 2 □ No
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> io	hysic this ce Il dire	၉	1 Maryes 2 □ No	Hospital: 1 Inpatient 2	ER/Outpatie		4 LI Nursing	Home 5 ☐ Reside	ence 6 Other (Spe	cify)
ב	ling P	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor		28d. Describe ho	ow injury occurred	
DIVISION	death death ctor: , the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Injury - At ho	me farm st		Yes 2 □ No	28f Location (St	reet and Number or Ru	ural Route Number
	al or A after Dire	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)			City or Town	n, State)	a man man man man man man man man man ma
	—To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use as	edical C		rsician: To the best of my kno iner: On the basis of examina and manner stated.						
	To the To the Somple of the So	≥	29b. Signature and title of certifier	/	· · ·	29c. Licens			9d. Date signed (Monti	
	5		· jall	. M.D		RES	5000	F	eb,06,	2009.
			30. Name and address of person who of Mendi Jalili	ompleted cause of death (Item 300) S	1 23a) (Type,	OVERS	+ 30	AITIMOT	BE WD	21225

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**Physician** 

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

by Funeral

Completed

Be

ဥ

Completed by Physician/Medical Examiner

Be

Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, II

**Physician** 

/Medical

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran

Baltimore, Maryland

/Medical

State Registrar 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number an we 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD M.D.TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32, Registrar's Signature

20th

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 12:08PM 2 9 2009 Samuel Lee Woodson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 2523 Aisquith Street Balto Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 52 219-62-1914 2-22-1956 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In in death Evaning must once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No by Funeral Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 2523 Aisquith Street USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Black 1 □ Yes 2 □No Specify. Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired).

Trans Factlity College (1-4or 5+) Elementary/Secondary (0-12) Maintenance Wörker 10th grade S.H. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Woodson Martha Goings ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Martha Woodson-Mother 2523 Aisquith Street Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Nebo Church 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Blackstone, 2-14-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 1101 E. MD 21202 wans North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Zhour **Physician** ardiac /Medical Due to (or as a consequence of): **Examiner** dilate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and m.m.y sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐Yes 2 ☐ No **Division of Vital** 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11th 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

09-01119 Jayden A		rspo	Please Type on amend #15,15ta	or Print in Bl	ack Ind Depart	elible lyk Ment of H	<b>ealth</b> ar	re All Copie nd Mental Hy	es Are Leg ygiene	ible.	2009	9 0436
			- For State		Certi	ficate of D	eath		Reg	. No.		
F Medical	hysicia	_	1. Decedent's Name (First, Middle,						Date of Death     Month     February 7	Day Y	ear 3	Time of Death 0727 hrs
Wedical	Exami		Jayden Alexander W  4a. Facility Name (if not institution,	give street and number)		4b. (	City, Town, o	r Location of Death			y of Death	
			University Hospital			B	Baltimore		•			
	uneral				e (In yrs. last		f Under 1 Ye			(MM/DD/YY	YY) 9. Birthp Count	lace (State or Foreign try)
D	irector		213-83-6922	X M 2 F		Yrs.	Months Day 5 5	,	09-02-20	008		MD
	ny		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Location					1	0d. Inside City Limits
> -	how a		MD	N/A			Balt	imore				1 X Yes 2 No
J O L	permit rages I and 2 smould be lifted within 12 nours arter deam with the Maryland Department of Health and Mental Hyg title. Inportanti. If them 27 is marked other than "natural", or items 23a or 28a-f show any Important. If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number			10	Of. Zip Code		10	g. Citizen of	What Country	y?
$\tilde{i}$	a or 2		527 N. Pulaski Stre	et			212:			JSA		
, in	ents 22 t be no	uneral	11. Marital Status 1 X Never Married 2 Man	12. Was Decedent Armed Forces?				lispanic Origin? ( Sp an, Mexican, Puerto			ice - America hite, etc.	n Indian, Black,
to to	or ite	Fun		1 Yes 2	X No	1 Ye	s 2 X N	o specify:		Specif	African	American
d s	toral"	d b	15. Decedent's Education (Specif	or Dates:	npleted) 1	6a. Decedent's	Usual Occup	ation (Give kind of		16b. Kind of	Business/Ind	ustry
2	n "na	etec	Elementary/Secondary (0-12)	College (1-4 or	5+)	during most	-	e. DO NOT use re.	ed)		Infant	
5-0036	er tha	Completed	Infant			II-I-	Infan	18 Mother's Name	June Middle N			
-21-6 -5-1	Hyg		17. Father's Name (First, Middle, L	ast)		Unk.		Thaka With		aldeli Sama	ine)	
2121	Menta Menta marko c even	o Be	19a. Informant's Name/Relationshi	p (Type, Print )		19b. Mailing Ad	ddress (Stre	eet and Number or		ber, City or T	own, State, 2	Zip Code)
MD	2 sho th and 27 is umati		Thaka Witherspoon -	- Mother				Street Balt		21223		
<u>.</u>	FHealt Fitem Fitem		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from St	ata Cre	ace of Dispositio ematory or other			Date		n - City or To	own, State
OE	Pages nent of ant: I		4 Donation 5 Other Spe	L	Mt.			and the same of th	6-2009	Baltimo	•	
Baltimore,	ermit. eparti mport ijury	- 1	21 Signature of Funeral Survice L	ic-insee		22. Nam	ne and Addre	ss of Facility Wy1	ie Funeral	. Home F	•A.	
		_	23a. Part I. Enter the disease, or c	on plications that caused	the death. [	1 638	N. Gilmo	or Street B	altimore.	MD 2121	7	Approximate Interval
	ysician Jedical		failure. List only one cause of	n each line.				n Infancy			64	Between Onset and Death
- F	aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		IIIIcu De	Jacii I	i Infancj	(BODI)			
		L	Sequentially list conditions,	b								
		nine	If any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence or):							
W.	sit d	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):							
\	xecuted n and I - transit	ल	X UNPENDED	AMENDED 23	a.27.5	28a-f pe	er me	g891 5-1-	09 vt			
.00	ficate be exe g physician the burial -	sician/Medic	IF FEMALE:	23c. If yes, outco					-	23d. Date	e of delivery	
Box 68760,	ertifica ding pl	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal	40041	Ectopic pregn	ancy	Mont	h Da	ay Year
ŏ,	leath certific e attending I for use as th	sici	1 Yes 2 No 9 Unkr		t time of dea	th 5 Other	r (Specify)					
. B	law requires that the de has been signed by the 2 should be detached f	Phy	Part II. Other significant condition	ons contributing to dea	th but not res	sulting in the und	lerlying cause	e given in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?
, P.O.	res tha signed be det	d by							1 Yes			ably 4 🗹 Unknown
Division of Vital Records,	requi	Completed							24a. Was autop	sy	prior to co	opsy findings available impletion of cause of
eco	he lav ate has age 2	omp							1 Yes	med? 2 No	death? 1 ✔ Yes	2 No
<u>8</u>	ian: T certific ctor, p	Φ.	25. Was case referred to medical examiner?					ce of Death (Check				
Zi.	hysic rthis c al dire	To B	1 ✓ Yes 2 No			ER/Outpatient 28b. Time of Inju		Other: Nurs	ing Home 5	Residence		
n of	ding I h. Afte funer		27. Manner of Death  1 Natural 5 Pendi	28a. Date of Inj (Month, Day,		7:15a	· I _	Yes 2 X No			oun ou	
isio	Atten r deatl ector; by the	icati	2 Accident Inves	igation 28e Place of I	njury - At ho	me, farm, street,			28f. Location (	<b>1</b> Street and Ni	ımber or Rur	al Route Number, City
Div	ital or irs afte ral Dir lled in	Certification:	3 Suicide 6 X Could determ	not be					Baltimo	ore, M	N. Pi arylan	d St.
	To the Hospital or Attending Physician: The law requires that the death certificate be ex- within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial		29a. Certifier 1 Certifying Ph	vsician: To the best of r	ny knowleda	e. death occurre	d at the time,	date and place, ar	d due to the caus	e(s) and ma	nner as state	d.
	To the within Fo the	edical	one) 2 Medical Exam	niner: On the basis of example manner stated	amination an	d/or investigation			at the time, date			
	XU	ž	29b. Signature and title of certifier	1 11	/			ense number			signea <i>(Mon</i> y 8, 2009	th, Day, Year)
	Jam.	,	41	NI. ICE				J.IV1. □.		Corda	, 0, 2000	
	Jam.		30. Name and address of person Jack Titus MD. Dep	who completed cause of uty Chief Medical !		<sup>23а)</sup> 111 Penn	Street, B	altimore, MD 2	21201			
	1	tate			ar's Signatur		., -					
	Regis			2009	2210	A pa	that					
DHMH	17 Rev 1/2	2001	( LU	& mann \		ORIGINAL					OCI	ИE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Examiner 4b. City. Town, or Location of Death 4c. County of Death (In vrs. last birthday) **Funeral** Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🝊 F Months Days Hours Min Director 10a. State 10b, County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No timore reet and Number 10g. Citizen of What Country? 21206 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 No Specify: Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ife. DO NOT use retired). is marked other than College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First. Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked or any Injury or other impress 2 should be fi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wiece) Denise Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) re of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of di Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RinentiA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a o 9 Unknown 9 Unknown <u>~</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performe certificate of Vital 2 No 1 ☐ Yes 1 ☐ Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the ft 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 2 uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of N	laryland / Dep		lealth and N	lental Hy	giene		04371
-	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle Gary Louis Warren 4a. Facility Name (If not institution Sina; Hospi	give street and numbe		4b. City, Town, or Baltimor	Location of Death	2. Date of De Month Feb man	ath Day	Year 2009 y of Death	3. Time of Death 9:16 PM
	Funeral Director		5. Social Security Number 213-84-2472 Usual Residence of Decedent		ge (In yrs. last birthday 47  Yrs.		lf Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 09–12–19		9. Birthplac	ce (State or Foreign ') MD
	ie Marylan 8a-f show	ctor	MD 10b. County N/A		10c. City, Town or L Baltin				-	10d.	Inside City Limits  1X□ Yes 2 □ No
	th with the 23a or 2	<b>Funeral Director</b>	10e. Street and Number 3800 W. Belvedere Av	e Apt 503		10f. Zip Code	21215		10g. Citizen of USA	What Country	?
.0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Madical Experiment roughled at	5	11. Marital Status  1 Never Married 2X Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates	: <b>(</b> No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	ecify Yes or No Rican, etc.)	Specia		American
21215-0036	within 72 jiene. r than "nat	Completed	15. Decedent' (Specify only highes  Elementary/Secondary (0-12)  12th	s Education t grade completed) College (1-4or	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired Lal	<sup>ation</sup> luring most of worki borer	ing	16b. Kind of B	Business/Indus	try
	3.2 should be filed within ith and Mental Hygiene. 7 is marked other than "raumatic event, "in Max	To Be C	17. Father's Name (First, Middle, L William Warren				18. Mother's Name	ren			
, Ma	1 and 2 st Health an em 27 is r		19a. Informant's Name/Relationsh Arnechia Warren – W		3800 W	ng Address <i>(Street a</i>	Ave Apt221				ode)
Baltimore, Maryland	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition  1 Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Signau d. Funer Service)	ecify)	Metro Crema	osition (Name of matory or other place tory 2. Name and Addres	02-16-		20c. Location  Baltimor  Home P.	ce. MD	, State
	Physician /Medical Examiner	dical Examiner	23a. Part 1. Enter the disease, or o shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any Leading Learned to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or at b. Due to (or at c. In t	d the death. Do not en	cemio tis	g, such as cardiac o	or respiratory a		1	oproximate terval Between nset and Death WEEK WEEK
.O. Box 68	that the death certificate ned by the attending physi detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)				ite of delivery onth Day	y Year
rds, P.	iw requires that s been signed b should be deta	þ	Part II. Other significant condition	s contributing to death	but not resulting in the u	nderlying cause give	n in Part I.		obacco use cont		ause of death?
Vital Records	ician: The law rec certificate has bee ector, page 2 shou	Completed	Non-Hodgh	ains lym	iphoma			24a. Was a autop perfor 1 □ Yes	sy med?	prior to comple death?	findings available etion of cause of
of Vit	ys dir	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	<del></del>	nt 3 DOA Othe	_ 4 ☐ Nursing Hor			ner (Specify)	
Division	or Attending after death. Director: After in by the fune	Certification:	27. Manner of Death  1 Whatural 2 Accident 3 Suicide 6 Could no determin	t be 28e. Place of In	ury - At home, farm, str	M 1 □Y	es 2□No		ow injury occurr treet and Numb n, State)		oute Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	Physician: To the best xaminer: On the basis and manner st	of examination and/or in	h occurred at the tim vestigation, in my op	ie, date and place, a pinion, death occurr	and due to the ded at the time, d	cause(s) and madate and place,	anner as state and due to the	d. cause(s)
		2	29b. Signature and title of certifier	jm,	MD	29c. License	S - 000		29d. Date signed Febma		
	) Sta	te	30. Name and address of person by FW A . 31. Date filed (Month, Day, Year)	no completed cause of o	death (Item 23a) (Type,	Print) Hospital	of Ba	Itimo	re		
	Registr	ar	FEB 13	2009	un p. of	arke					

			For State Registrar	State	of Marylar	nd / Depa <i>Cer</i>	ertment of H	lealth a Death	ınd Me	ntal Hyg	iene <sub>eg. No.</sub> 2 (	009	04372
	Physici /Medi		1. Decedent's Name (First, Midd Ting Yook Wu						2.	Date of Deat Month ebruary	h Day	Year	3. Time of Death  3:40A. M
الله الم	Examir		4a. Facility Name (If not institution  Sanctuary at Holy	_	number)		4b. City, Town, or Burtonsv.			<b>,</b>	4c. Count	ty of Death	1
	Funeral Director		5. Social Security Number 060-28-6230	6. Sex	7. Age (In yrs.	74 Yrs.	if Under 1 Year Months Days	If Under 2 Hours	Min. A	Date of Birth (Month, Day, pril 9,	Yea <i>r)</i> 1934	9. Birthp Cour New Y	place (State or Foreign htry) Ork
	Maryland f show ied at	tor	Usual Residence of Decedent  10a. State 10b. Count  Maryland	y Howard	10c. Ci	ty, Town or Lo	cott City					1	10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28a- st be notif	Il Director	10e. Street and Number 5230 Dorsey Hall		z, 203		10f. Zip Code 21042	2		10	0g. Citizen of U.S		ntry?
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene.  marked other than "natural", or items 23a or 28a-f show imatic event, the Me Itcal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Ma	12. Was D Armed 1 1 Ye	ecedent Ever in U Forces? es 2 1 No Give		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2k No	ispanic Orig in, Mexican, Specify:	jin? (Specif , Puerto Rid	y Yes or No- an, etc.)	14. Ra	ack, White,	etc.
Maryland 21215-0036	hin 72 hours e. an "natural' Me iical Ex	Completed b	3 ☑ Widowed 4 ☐ Divorce  15. Decede (Specify only high  Elementary/Secondary (0-12)	nt's Education est grade complete	ed) e (1-4or 5+)	(Give	ent's Usual Occupa kind of work done o OO NOT use retired	ation during most	of working		16b. Kind of E	Chin Business/Ind	
Ind 21	be filed wit ntal Hygiene of other the event, the	Be	17. Father's Name (First, Middle			Cleri	cal			irst, Middle, N	Bar Maiden Surna		
магуіа	2 8 8	2	Tow Wy Yee  19a. Informant's Name/Relation				g Address (Street a	and Number		loute Number,			
altimore, I			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		om State	Place of Dispos cemetery, cren	Littleton Sition (Name of natory or other place	e)	Date	9 2	20c. Location	- City or To	own, State
Baltir	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other ( 21. Signature o Funeral Service			rison For Vi 283 55	rest Name and Addres <b>tzke Funera</b> 55 Twin Kno	s of Facility	2-9-200 s, Inc				Maryland
المثا	Physician.		23a. Part1. Eriler the disease of shock, or heart failure. List Immediate Cause (Final disease or condition	or complications that only one cause of	at caused the deat		er the mode of dying	g, such as c		espiratory arre		1 110 13	Approximate Interval Between Onset and Death
	Cate be executed bhysician and the burial-transit the burial-transit	I Examiner	resulting in death)  Figure 1 and 1	b	to (or as a consequence to (or a consequence to (or a consequen	(EF#6 juence of):	tis Of	= J	476	ζ _			
O. Box 68/60	eath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooms? 1 □ Yes 2 □ No 9 □ Unknown	1□Liv 4□Pr	outcome pf pregnare birth 2 ☐ Feta egnant at time of d	al death 3	Ectopic pregnancy Other (specify)					ate of delive	ery Day Year
cords, P.	w requires that the d been signed by the should be detached	by	Part Other significant condit	ions contributing to	e death but not res		derlying cause give	en in Part I.				tribute to th	ne cause of death?
I Kec	The larate has	Completed								24a. Was an autopsy perform 1☐ Yes 2	red?	prior to cor death?	psy findings available npletion of cause of
	this ald	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manper of Death	Hospital:	□ Inpatient 2 □	ER/Outpatient		r: 4 Nurs	sing Home	5 Reside	nce 6 □Otl		()
VISION	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	ng (M igation	lonth, Day Year) ace of injury - At ho ilding, etc. (Specif	Injury		? ∕es 2∐No	lo		eet and Numi		I Route Number,
5	Hospital or 4 hours aft Funeral Di tely filled in		(Check only 2 Medica	ng Physician: To I Examiner: On the	the best of my kno	wledge, death	occurred at the tim	ne, date and pinion, death	d place, and	due to the ca	use(s) and m	anner as st	ated.
	To the within 2 To the complete	Medical	29b. Signature and title of certific	and m	anner stated.		29c. License				d. Date signe		
1	V		30. Name and address of person	who completed ca	ause of death (Iten 2835	23a) (Type, F SmiTt	1/	SUI	TF o	^3	2/3/	0)	0.842-
	Sta Registr		31. Date filed (Month, Day, Year		Begistrar's Signa		3 Mars	- 4 J.	, - 2,	<u>, , )</u>	2,4	- ////	1040)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** 9, 2009 12:00 AM Walker February Vernett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 15, 1 9. Birthplace (State or Foreign Country)
Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 11XM 2∏ F 94 1914 Director 158-09-1265 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland | Prince George's Fort Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20744 3622 Luma Drive U.S.A. Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinat once. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 🖁 No Specify: Black Specify. ò 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Worker Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anderson Walker Mary Profitt Walker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Granddaughter) 3622 Luma Dr., Ft. Washington, MD 20744 Frances Foster 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2/13/09 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Prospect, VA 4 ☐ Donation 5 ☐ Other (Specify) Calvary Baptist Church 21. Signature of Furieral Service Liceni 22 Name and Address of Facility Bland-Reid Funeral Home 413 Griffin Blvd., Farmville, VA 23901 um 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementide disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year ed by the a detached for 5 ☐ Other (specify) P.O. I 9 Unknown 9 I Inknown signed by the detach The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown HYDERTENSION 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 2 certificate 1 Yes 1 □ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ၉ To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60 52999 MY Callellau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FER

13

10403

32 Registrar's Signature

HOSPITAL Drive G-06 CLINTON MU20735

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Weber **Physician** 00 a M Rosemarie 10 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Itospital Center Itimore da 8. Date of Birth Month, Day, April Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 200 Months Days Hours Min. 23/1932 219-28-0457 MD 76 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show MD Baltimore Essex Director 1 ☐ Yes 2 XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21221 940 Woodlynn Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) gosenarie 14. Race - American Indian, Black, White, etc. 1 Never Married 28 Married  $Webee_{\ell}$  Hosemalaltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft.
Department of Health and Merial Hyglens.
Important: If item 27 is marked other than "natural", or i any lnjury or other traumatic event, Its Medical Erani 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Stemler Louis Vanik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Woodlynn Road Baltimore Md 21221 Melvin E. Weber /husband 20b. Place of Disposition (Name of BayView Crematory or other place) 2/13/09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Signature of Juneral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cere bra disease or condition resulting in death) nTra /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) P.O. I signed by the a 1 ∐Yes 2 🖫 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 1210 After this certificate 2 No 1 ☐ Yes Division of Vital 1 ☐ Yes the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man or of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 1 Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 PR, JARWA NE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Ba Himire, Mid 21237 1) e vada Ha Registrar's Signature State 31. Date Wenth, Days Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February 10, 2009 8:30 Aw **Physician** Ernest Linwood Zittle, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie

If Under 24 Hrs. 8. Date of Birth
Ss Hours Min. June 23, Year) 16 Harding Road Glen
If Under 1 Ye Arundel 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days Months 215-40-7522 64 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showevent, I've Medical Examinations to notified at Director Md. Anne Arundel 1 ☐ Yes 2 ☑ No Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Harding Road 21060 U.S.A. Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☐ No 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give 1962-66 Specify by Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than "r College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen Important: If Item 27 is marked other the any injury or other traumatic event, IPs ODCE. Builder Land Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest L. Zittle, Elizabeth Lambiasi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Henry Harford Drive Abingdon, Md21009 Gina L. Byer (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA 2-17-09 Crownsville, Md. 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Litensei 1201 Dundalk Avenue Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner disease onau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate perform 2 🖾 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Cacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal completely (Check only one) within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D056038 February 12, 2009 30. Name and address of person who complete ause of death (Item 23a) (Type, Print) 21201 Ellen Rudikoff, Bari 10 North Greene Street Baltimore, Md M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			For State Registrar	State of Mary		partment of I <i>ertificate of</i>			ene 2009	9 04376
I	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
Ar. og	/Medic	al	Betty 4a. Facility Name (If not institution, given	Mae	A1		r Location of Death	01	24 09 4c. County of Dea	0642 M
-	Examin	er	WMHS Braddock			Cumbe			Alleg	
	Funeral Director		212-24-5584	Gex 1□ M 2\ F 81	n yrs. last birthda Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 12/23/19	year) 9. Bir 27 Mar	rthplace (State or Foreign ountry) yland
	and and		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	Maryl I-f sho	tor	MD Alleg	any	F]	intstone				1 □ Yes 2 🖔 No
	h with the 23a or 28a at be not	al Director	10e. Street and Number 10910 M.V. Smit	h Road, NE		10f. Zip Code	21530	100	g. Citizen of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, if a Medical Examination as the matthed at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 1	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify:	
Maryland 21215-0036	nin 72 hou e. an "nature Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	16a. De	cedent's Usual Occupive kind of work done or DO NOT use retire	oation during most of work d)	ing 16	6b. Kind of Business	
21;	ed with ygiene ier tha t, the	Com	12			Housekeep			Hospi	ltal 
yland	ould be file Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last Albert D	) David	Powe11		18. Mother's Name Minnie	e (First, Middle, Ma Ma	,	Knight
, Mar	and 2 sho salth and 1.27 is ma er traums		19a. Informant's Name/Relationship (Roy CLingerman /			ailing Address <i>(Street</i> 2 Old Will				Zip Code) 21530
altimore,	Pages 1 a lent of He nt: If item ry or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specia	J Hemovai from State 📙		sposition (Name of rematory or other plain nd Cremato	ry 01/27	/2009	oc. Location - City or Cumber1an	d, MD
Balti	permit. Departm Importa any Inju		21. Fignature of Funeral Service Lice			22. Name and Addres	ess of Facility Ada tur Stree	ms Family t, Cumber	Funeral	HOme, P.A. 21502
	Physician		23a. Part 1. Emer the disease) or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.		enter the mode of dyi		or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	ensequence of):	UN'S C	4MPHO1	7 A		5/2007
	cuted d ansit	Examiner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co		MONAR	y As	lREST		
68760,	ificate be executed g physician and is the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	ROBAB (				_
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as in	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		23d. Date of de Month	livery Day Year
rds, P.	quires that n signed bi	ρ	Part II. Other significant conditions of	contributing to death but no	ot resulting in the	underlying cause giv	en in Part I.			o the cause of death?
Vital Records,	sician; The law requir certificate has been s irector, page 2 should	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vita	ician; certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		iont 3 🗆 DOA Oth		h (Check only one)	600	
	ding Phys .r After this funeral dir	ion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Ye	2 ER/Outpat 28b. Time Injur	of 28c. Inju	4 🗆 Nursing Ho	me 5 ☐ Residence 28d. Describe how	ce 6 ☐ Other (Spe injury occurred	ecify)
Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director, p.	ertification: To	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 280 Place of Injury	At home, farm, Specify)			28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
_	e Hospita 24 hours e Funeral	Medical C		nysician: To the best of m niner: On the basis of exa and manner stated.	amination and/or					
	To th To th comp	Me	29b. Signature and title of certifier	D. 1111	,	29c. Licens	e number	29d	. Date signed (Mont	th, Day, Year)
	2		Alido	Soull	Va	D00	63467	<b>レ</b>	1/24/2	2009
	MRI		30. Name and address of person who Alida Rodrum	1 . 3 . 0	(Item 23a) (Typ		e Cumb	redand	MD 219	502
	Sta	е	31. Date filed (Month, Day, Year)  JAN 2 6 2009		Signature for	KN	<u> </u>		01	- 0
	Registra	II I	OUIA SO FOOD	Land	1					

Months

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Boone

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

Cumberland

Hours

Min.

2. Date of Death January 24,

Specify:

29d. Date signed (Month, Day, Year)

January 25, 2009

Geneva

7. Age (In yrs. last birthday)

Reg. No. 2009 04377 2009 1:00 P M 4c. County of Death Allegany 9. Birthplace (State or Foreign Country) West Virginia 10d. Inside City Limits 1 ☐Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc. White 16b. Kind of Business/Industry Sportsman's Club Cosner 20c. Location - City or Town, State Cumberland, MD Approximate Interval Between Onset and Death 3 years 23d. Date of delivery Month Vear 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

2

カメ

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 27

For State Registrar

5. Social Security Number

**Physician** 

/Medical

Examiner

**Funeral** 

1. Decedent's Name (First, Middle, Last)

Dorothy

4a. Facility Name (If not institution, give street and number)

514 Prince Georges Street

1 □ M 2 ₩ F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robustiano J. Barrera, M.D., 500 Memorial Avenue, Cumberland, MD

3. Registrar's Signature

29c. License number

D0014865

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

09-01034 Timpthy Borden

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 04379

		1- For State Registrar	-	Certit	ficate of l	Death		, 0	Reg. No	0.	
Physicia		Decedent's Name (First, Middle,	Last)		_	· -		2. Date of	Death		3. Time of Death
edical Exami	ner	Timothy Paine	Borden					Month Februa	Day 1ry 4, 20	year 009	1211 hrs
		4a. Facility Name (if not institution,	give street and number)		<b>4</b> b	. City, Town, o	or Location of			4c. County of Death	1
		Northwest Hospital				Randallsto	wn			Baltimore Cou	ınty
Funeral		Social Security Number 6	. Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Ye	ear If Under	24Hrs. 8: Date of	of Birth(MI	M/DD/YYYY) 9. Bir	
Director		444-72-3146	X M 2 F	48	Yrs.	Months Da	ys Hours	Min. 7/2	5/196	Foreig	in untry) MD
		Usual Residence of Decedent	21 2	40				1/2.	J/ 190	0	· MD
ıny		10a. State 10b. County		10c. City, To	own or Location	n					10d. Inside City Limits
6. W. 1		MD Anne Ar	rundo1	Sa	vern						1 Yes 2 X No
rylan a-f sl	흻	10e. Street and Number	didei	56		10f. Zip Code			10n C	itizen of What Cou	
ne Maryland or 28a-f show any fied at once.	Director	8524 Braun Ave					21144		103.0		,.
with the Maryland ms 23a or 28a-f sho be notified at once.		11. Marital Status		F :- 11.0	40.14/	Daniel de la constitució		-2 / C-+-it- V		USA	la de Biration
tens	Funeral	1 X Never Married 2 Mar	12. Was Decedent Armed Forces?					n? ( Specify Yes o Puerto Rican, etc.		White, etc.	ican Indian, Black,
er der , or i	F		1 Yes 2	X No	4	/ 0 V N				C*	777 4 .
rs aft pral" mine	ρ	15. Decedent's Education (Specif	or Dates:	aploted) 11		Yes 2 X N		nd of work done	1165	Specify: . Kind of Business/	White
hour "nati	ted	Elementary/Secondary (0-12)	College (1-4 or			st of working li			100	. Killa of business/	·
36 han dical	릛	8	John College (1 4 of 1	5.7	C	arpente				Compte	40 d
-00 I with	Completed	17. Father's Name (First, Middle, L	ast)		0.0	ar pence		Name (First, Mid	dle Maide	Construc	LIOII
15 al Hy	Be	Joseph Paul Bon						aret Sm		o. odmano,	
212 uld ho mark	0	19a. Informant's Name/Relationship		- 4	19b. Mailing	Address (Stre				City or Town, State	e. Zip Code)
1D 2 short and and martic		Terry Lee Burd:		ster		Braun A		Severn, 1			.,,
imore, MD 21215-0036  Pages 1 and 2 should he filed within 72 hours after hent of Health and Mental Hygiene and fitten 75 is marked other than "natural", or other trannatic event, the Medical Examiner.		20a. Method of Disposition		20b. Pla	ice of Disposit	on (Name of c		Date		c. Location - City or	Town, State
Ore ges 1 t of F : If i		1 Burial 2 X Cremation		aic	matory or othe			2/0/200		11 7	
Baltimore, MD 21215-0036 mit Pages I and 2 should he filed within 7 Department of Health and Mental Appgiene important: If item 27 is marked other than ujury or other transmatic event, the Medica		4 Donation 5 Other Spe		АСТА	ntic C:			2/8/2009		Glen Burn	ie, MD
Baltimore, MD 21215-0036 pemit Pages 1 and 2 should he filed within 72 hours after death with the Maryland Departure of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	eys 4		22. Na	ime and Addre	ss of Facility.	lardesty	Fune	ral Home	, P.A.
	-	23a. Part I. Enter the disease, or co	mplications that caused	the death D	I12	Ridgely	Ave.	Annapo	is,	MD 21401	Approximate Interval
Physician /Medical		failure. List only one cause of	n each line.							stick, of fleat	Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Complicat  Due to (or as a cons	ions o	of hype	rtensi	ve athe	eroscler	otic		Death
		-	Due to (or as a cons	equence of):	caraio	vascura	ar arse	ease			
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):							
	ᄩ	cause. Enter Underlying Cause (Disease or injury that initiated	c								
sit sat	Examiner	events resulting in death) Last	Due to (or as a cons	equence of):							
760, Trate be executed physician and the burial - transit		77	d23	a,27,p	erME,	g889 3,	<del>/20/09</del> -	TT			
D, be es sician	/Medical	X UNPENDED	AMENDED	, ,1			,				
760, ficate be g physici the buri	W/	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	me of pregnar					2	23d. Date of deliver	
certifications as a seas	ciar	past 12 months?	1 Live birth Pregnant at	time of death	_ =	al death 3	Ectopic	pregnancy	]	Month	Day Year
Box 68	Physicia	1 Yes 2 No 9 Unkn	own g Unknown		5 Otni	er (Specify)			-		
D. E tt the by th		Part II. Other significant condition	ns contributing to deat	h but not resu	ulting in the un	derlying cause	given in Part	I. 23e.	Did tobaco	co use contribute to	the cause of death?
of Vital Records, P.O. this Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	by							1	Yes 2	No 3 Pro	bably 4 🗸 Unknown
ds, equir	Completed							24a. '	Was an		utopsy findings available
COT law l has t	ldu								autopsy performed		completion of cause of
Re The ficate	Ö								res 2 ✓	No 1 Y	es 2 No
ciam:	Be	25. Was case referred to medical examiner?	Hospital:				Other:	Check only one)			
Physi	ဥ	1 ✓ Yes 2 No	Праце		R/Outpatient		4	Nursing Home		idence 6 Othe	rr:
Afte funer		27. Manner of Death  1 X Natural 5 Pendir	28a. Date of Inju (Month, Day,)	Jry 2 (ear)	8b. Time of Inj		jury at Work?		ribe how i	injury occurred	
SiOI Mittem death ctor:	ati	2 Accident S Pendir	gation				Yes 2				
Division of Vital Records, P.O. ours after death of the death of the death of the death or the law requires that the recal Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could		njury - At hom	ne, farm, street	, factory, office	e building, etc.		ion (Stree wn, State)		ural Route Number, City
Spita Spita Spita Spita	Se	4 Homicide determ	(Specify)								
n 24 re Fin	ca		sician: To the best of m								
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Fineral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		iner: On the basis of exa and manner stated.	- A	, or investigation			arrea at the time,			
6.	2	29b. Signature and title of certifier	. 150	//	1	1 .	nse number			d. Date signed (Mo	
CARL		(alle	V CE	1	(	0.0	C.M.E.		Fe	ebruary 5, 200	9
1 1/2		30. Name and address of person w	•		*						_
•			ssistant Medical E			Street, Ba	iltimbre, M	D 21201			
St Regis	tate	31. Date filed (Month_Day, Year)	2009 32. Registra	r's Signature	h ha	. 4.1		_		· <del></del>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month BALTHAZAR 2009 JACQUES ANTHONY 01 21 135 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ab. City, 10min, School Rock Ville, MARK 7217 ND |

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

The Days | Hours | Min. (Month, Day, Year) SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□F 2009 MARYLAND NONE Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annex pines. 10c. City, Town or Location 10a. State 10d. Inside City Limits SILVER SPRING, MARYLAND MONTGOMERY 1 X Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20901 1108 LANE CHISWELL 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed by 3 Widowed 4 Divorced MIXED 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) INFANT INFAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RICHARD BALTHAZAR မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCHUMACHER / MOTHER LANE, 1108 SILVERSPRING, MD 20901 CHISWELL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State STERI HALL RIVER, NC CYCLE 02 23 2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens GAH, 9901 MEDICAL CENTER DRIVE, KOCKVILLE, MO 2085C 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PREMATURIT Immediate Cause (Final **Physician** EXTREME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 1 ☐ Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence After this 28a. Date of Injury 6 ☐Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0038971

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 04381 For State

Physici /Media Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Sta Registrar

_	Registrar	Certi	iticate of L	Jeath		Reg	. No.		
	1. Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Va		3. Time of Death
an :al	Wilson	Cla	V			January	27 200		4:58 AM
er	4a. Facility Name (If not institution, give street and number)		b. City, Town, or	Location o	f Death		4c. County of D	eath	'
	Frederick Memorial Hospital		Frederi	ick			Frede	ric	k
	5. Social Security Number 6. Sex 7. Age (In yrs. last bi		If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birth (Month, Day, Y	9.	Birthp	lace (State or Foreign
	220-28-3833   <sup>1⊠M 2□ F</sup>   83	Yrs.	Months Days	Hours	Min.	July 20, 1	925	Coun Mar	yland
	Usual Residence of Decedent	1				20,1	, , , ,		Jama
	10a. State 10b. County 10c. City, Tow	vn or Loca	tion					10	0d. Inside City Limits
ξ	Maryland Frederick Thurmo	ant							1 ☐ Yes 2X No
Je C	10e. Street and Number	)II C	10f. Zip Code			100	. Citizen of What	Coun	trv?
<u> </u>				.00		1.53			,
era	11.3 Dogwood Avenue  11. Marital Status 12. Was Decedent Ever in U.S.	12 14/2	217		-in2 (Cno.	oif. Va a ar Na	United S		
Ë	Armed Forces?	IS. Wa	is Decedent of Hi es, specify Cuba	n, Mexican	, Puerto R	Rican, etc.)	14. Race - A Black, W		
5	If Yes, Give	10	]Yes 2⊠No	Specify:			Specify:		
Be Completed by Funeral Director		Decede	nt's House Coours	ation				Whi	
lete	15. Decedent's Education (Specify only highest grade completed)	(Give kir	nt's Usual Occupa nd of work done d NOT use retired.	lurina most	of working	g 16	b. Kind of Busine	ess/inc	lustry
Ē	Elementary/Secondary (0-12) College (1-4or 5+)	me. DC	_				***		
ပိ	6		Farmer			(F) 1 44 1 1 1 44	Farr	nln	g
	17. Father's Name (First, Middle, Last)					(First, Middle, Ma	den Surname)		
၉	Wilson Carroll Clay		-	Edna	P. K	ing			
	19a. Informant's Name/Relationship (Type. Print)	b. Mailing	Address (Street a	and Numbe	r or Rural	Route Number, C	ity or Town, Sta	te, Zip	Code)
	Carolyn Jacobs/ Daughter 24	4312	Welsh Ro	ad, G	Gaith	ersburg,	Marylan	nd	20882
	20a. Method of Disposition 20b. Place of cemeter	of Disposit	ion (Name of tory or other place	e)			c. Location - City	or To	wn, State
	TEPBUIRI 2 LI CIETIATION 3 LI REINOVAI ITOM State		Memorial	i 1	/31/2		ederick,	M	aruland
	21. Signature of Funeral Service Licensee						ederick,	LIC	ary rand
	+ bold Allemin	162	uffer fu 1 Opossu	mtown	l Hom Pik	es P. A. e. Frede	rick. Ma	arv	land 21702
	23a. Part 1. Enter the disease, or complicators that caused the death. Do shock, or heart failure. List only one bruse on each line.								Approximate
	and the second s			3,		,	•		Interval Between Onset and Death
	disease or condition resulting in death)	-	Orchan					$\perp$	
	Due to (or as a consequence	of):							
7	Sequentially list conditions, bb.	of\.						_	
in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(01):							
xan	that initiated events resulting in death) Last C	of):						+	
E E	Due to (or as a consequence	01).							
n/Medical Examiner	d							+	
Me	IF FEMALE:								
an/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deatl	h 3□E	ctopic pregnancy	,			23d. Date of		,
Sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5□0	Other (specify)				Month		Day Year
Be Completed by Physicia	9 Li Unknown						1		
by	Part II. Other significant conditions contributing to death but not resulting it	in the unde	erlying cause give	en in Part I.		23e. Did toba	co use contribut	e to th	e cause of death?
ed						1 ☐ Yes	2 □ No 3 □	] Prob	ably 4 🔀 Unknown
plei						24a. Was an	24b. Were	auto	osy findings available
mo						autopsy	d? deat	h?	npletion of cause of
e C	25. Was case referred to medical	of Dooth	1 ∐Yes 2X (Check only one)	No 1□	Yes	2□No			
9 O	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/O			. с По#h //		,			
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								specit)	/)
tio	1 Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	Work	? Yes 2∐N			injury coouring		
fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home fr			8f. Location (Stree	at and Number o	r Pum	I Pouto Number		
erti	4 ☐ Homicide determined building, etc. (Specify)	,		State)	illuia	i i loate Ivamber,			
O E	29a. Certifier 12 Certifying Physician: To the best of my knowledge	ne. death o	occurred at the tim	ne date an	d place c	and due to the ac-	ea(e) and man-	Y 00 0	tated
lica	(Check only one)  Addical Examiner: On the basis of examination a one)	nd/or inve	stigation, in my o	pinion, dea	th occurre	ed at the time, date	se(s) and manne e and place, and	due to	the cause(s)
Mec	29b. Signature and title of certifier								
1	. 00	29c. License number 29d. Date signed ( <i>Month</i> , <i>Day</i> , <i>Year</i> ) 1 - 2 7 - 2009							
	▶ Wondey, M.D.		MDD64	910			1-2-	+ -	2009
	30. Name and address of person who completed cause of death (Item 23a)								
	Pratina Pandey M. D. 400 West 7th	eet, Fre	deric	k, Ma	aryland 2	21702			
te	31. Date filed (Month, Day, Year)  32. Registra's Signature  JAN 3 0 2009	1	harkel						
ar	JAN 3 U ZUUS > LEREUN	19.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04382 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN 27 2009 5:00 PM ARLINGTON FICHTNER CAMPBELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral 1** M 2□ F Months Days 232-62-8480 69 Yrs. Director March 11, 1939 Óhio Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be redified at Fairfax Virginia Springfield Director 1 ☐ Yes 2 XNo 10e. Street and Number 7903 Marysia Court 10f. Zip Code 10g. Citizen of What Country? 22153 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★XYes 2 □ No If Yes, Give Year or Dates: 1961–94 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married XX Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Admiral 5+ U.S. Navy s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Arlington Campbell Ruth Fichtner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie J. Campbell/wife 7903 Marysia Ct. Springfield, Virginia 22153 Department of Health Important: If Item 27 any injury or other tr 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Naval Academy Cemetery 2/6/2009 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Tuneral Service Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC MESOTHELIOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least conditions, if any least cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XX XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ₹ No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral 27. Manner of Death 1 🖾 Natural 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation n 24 hours after death.

• Funeral Director: A pletely filled in by the fi death. 2 Accident 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the

X1.10+1

State Registrar 29b. Signature and litle of certifier

AMY J ZWETTLER

31. Date filed (Month, Day, Year)

USN

32. Redistrar's Signature

LT

MC

29c. License number

0116019919 (VA)

29d. Date signed (Month, Day, Year)

JAN 28 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

DHMH 17 Rev 1/2001

2

backer

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $\mathbf{P}$  M EVELYN ELIZABETH CECIL 29 2009 2:10 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 416 ROLLING BRIDGE ROAD **CENTREVILLE** QUEEN ANNE'S 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6. Sex **Funeral** Days 1 □ M 2 **X** F **Director** 219-36-5348 68 APRIL 17,1940 MARYLAND Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo QUEEN ANNE'S MARYLAND CENTREVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 416 ROLLING BRIDGE ROAD UNITED STATES 21617 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No ģ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 72 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ J. EDWARD BURRIS ROSA MAE RADCLIFFE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAURICE VINCENT CECIL/HUSBAND 416 ROLLING BRIDGE ROAD, CENTREVILLE, MD 21617 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FEB. CHESTERFIELD CEMETERY 2009 CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi). Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 Anemia Chronic 1 ☐ Yes 2 ☐ No 3 Probably 🖈 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 200 main D.O. PHYCICIAN 30. Name and address of pe/son who completed cause of death, (Item 23a) (Type, Print) 2540 Road Centrulle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			_ For	State of M		/ Depa	rtment of	Health and I		ijene	01 201
			1 - State Registrar			Cer	tificate of	Death		eg. No. 2009	04384
I	Physic /Medi		1. Decedent's Name (First, Mid Robert		arold		Dep	ew	2. Date of Deat Month	Day Year 27 2009	3. Time of Death
and a	Exami		4a. Facility Name (If not institut	ion, give street and number)			4b. City, Town,	or Location of Death		4c. County of Death	
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	Funeral Director		5. Social Security Number  188-18-8447  Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. las 82	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 03/09/19	Year) 9:•Birth	place (State or Foreign ntry) Sylvania
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Baltimore,	mit. Pages bartment of cortant: If i Injury or		4 □ Donation 5 □ Other (	Specify)	Cumb			ory 01/28		Cumberland	, MD
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State Registrar	State of Ma	arylan		artment of F rtificate of .			giene, Reg. No.	009	04385
-		Decedent's Name (First, Middle, L.)	ast)	_				2. Date of De	ath	Vass	3. Time of Death
Physicia /Medic		James Lewis	Davis					Februar	ry 5,	2009 Year	4:45 A M
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		9505 Wire Av					er Spring			ontgom	
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ter de item	E.	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Armed Forces? 1 XYes 2		5.   13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	14	. Race - Ame Black, Whit	
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with To	Σ	29b. Signature and title of certifier	en Ba	tea		29c. Licens	678		29d. Date	signed (Mont	h, Day, Year)
(11)							5 / 0		Feb	ruary	6, 2009
		30. Name and address of person wh  Rajeev Batr					ο Δ	041			
Sta	te	31. Date filed (Month, Day Year)		ar's Signat	ture	Hampshir	e Avenue	<u> 511ver</u>	Spri	ng, Ma	ryLand
Registr		LER () ?	1 200 B	esce-s	p. 1	parked					

Tomasa

3470 Hipsley Mill Road

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Hospital or Attending Physiclan: The law requires that the death certificate be executed to bus after death. Box 68760, P.O. Division of Vital Records, After this

8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🕱 F Months Davs Hours Director 585-05-9920 66 May 11, New Mexico 1942 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at **Funeral Director** 1 ☐ Yes 2 No Maryland Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3470 Hipsley Mill Road 21797 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ∑Yes 2 □ No 1 ☐ Never Married 2 🕅 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Anita Villa ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth C. Daly / Husband 3470 Hipsley Mill Road Woodbine, Maryland 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory 5, 2009 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) I □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🖾 No I □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ∏Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clement B. Knight, M.D. 11065 Little Patuxent Parkway Columbia, Maryland 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dal<sub>v</sub>

Certificate of Death

4b. City. Town, or Location of Death

Woodbine

2. Date of Death

February

3. Time of Death

2009

Howard

4c. County of Death

8:00 P M

P.O. Box 68760, of Vital Records, Division

the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death, the Funeral Director: A maletely filled in by the fi within 2 To the

> State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number D26907

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

FEBRUARY 10.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Bishop Walsh Rd Cumberland, MD21502 MD

32. Registrar's Signature

DK

Amended #10c, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 01/26/09, Allegany Co. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registral 14388 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 15:40 James Harold Emerick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner wm45memo Allegan 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2 □ F 87 Yrs. 184-18-3121 Director PA 3-30-1921 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ire Modical Examiner must be natified as Director 1 X Yes 2 No MD Allegany -730-Furnace-St. Cumber1and 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Furnace St. USA Funeral 21502 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐YNo IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Delivery Man Dairy Supplier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown မ Pearl Emerick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2
Department of Health ar
Important: If Item 27 is r. Diana L. Emerick/ Daughter 312 Palo Alto Rd., Hyndman PA 15545 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 1-23-2009 Cumberland MD 22. Name and Address of Facility Harvey H. Z eigler Funeral 21. Signature of Funeral Service Licensee Home Inc 169 Clarence St Hyndman PA 15545 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LCUTE RESPIRATORY FAILURE disease or condition resulting in death) ONE DAY /Medical Due to (or as a consequence of): Examiner SPIRATION ONE DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): law requires that the death certificate be executed Exami burial-tran and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 5 ☐ Other (specify) the detached 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Jas page 2 certificate 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation in 24 hours and the true the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 01-22-09 D14865 memorial Ave. 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) TILS

State Registrar 31. Date filed (MJAN 2 6 2009

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Registrar's Signature

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar is used by notified at once.

EAves, Donald Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

•	1 - State Registrar	ne or maryiand	Certific				eg. No.	109 04389
n	1. Decedent's Name (First, Middle, Last)					Date of Deat     Month	th Day	3. Time of Death
ai	DONALD EDW					Februai	cy 5 2	2009 9:25 A M
er	4a. Facility Name (If not institution, give street a				Location of Death			ty of Death
	Berlin Nursing & Re	7. Age (In yrs. las		Berli der 1 Year	.n If Under 24 Hrs.	8. Date of Birth		ester  9. Birthplace (State or Foreign
	220-05-6360  Usual Residence of Decedent		Yrs. Mon	hs Days	Hours Min.	8. Date of Birth (Month, Day, NOV • 9,	Year) 1919	Country) Maryland
i	10a. State 10b. County	10c. City,	Town or Location		<del></del>			10d. Inside City Limits
cto	Maryland Worcester	C	cean Ci	ty				1 □ Yes AND
Ö	10e. Street and Number		10f	Zip Code		1	0g. Citizen of	f What Country?
ā	10045 Bonita Dr.			2184			United	l States
Be Completed by Funeral Director	1 Never Married 2 Married 1 №	s Decedent Ever in U.S. ned Forces? ]Yes 2 □ No es, Give ar or Dates: WW II	1 🗆 🗸	ecedent of H specify Cuba s 2∭No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - American Indian, ack, White, etc. ify: White
eted	15. Decedent's Education (Specify only highest grade comp		16a. Decedent's	Jsual Occup	ation during most of work	ina	16b. Kind of E	Business/Industry
mple		llege (1-4or 5+)	life. DO NO	T use retired	) -			
ပိ	17. Father's Name (First, Middle, Last)		Sales F	epres	entative 18. Mother's Nam			Company
	Thomas	Eaves			Florenc			,
2	19a. Informant's Name/Relationship (Type. Prin		19h Mailing Add	ross (Stroot			ddinge	n, State, Zip Code)
	Patricia Currence /	. *	_		Drive /		-	
	20a. Method of Disposition	20h Pla	ce of Disposition	Name of	1			n - City or Town, State
	1 X Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	ol from State Glad	metery, crematory de Cemet			2009	Walkers	sville, MD
	21. Signature of Funeral Service Licensee	1			ss of Facility St	auffer F	unera1	Home
	Commond De	erson	1621	0poss	sumtown P	ike/Fred	erick,	MD 21702
	23a. Part 1. Per the disease, or complications shoot r heart failure. List only one caus	that caused the death. se on each line.	Do not enter the	mode of dyir	ig, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Immediate Cause (Final disease or condition	ASCVO						Onset and Death
	resulting in death)	Due to (or as a conseque	ence of):					
_	Sequentially list conditions, b.							
nin	cause. Enter Underlying	Due to (or as a conseque	ence of):					
xar	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
g	d							
edic	u							
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   9   Unknown   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   Month   Day   Yes							
y Ph	Part II. Other significant conditions contributing	ng to death but not result	ting in the underlyi	ng cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to the cause of death?
ed b						1 🗆 Ye	es 2□No	3 Probably 4 ☐ Unknown
plet						24a. Was a		. Were autopsy findings available prior to completion of cause of
ĕ						perfori	med?	death?
Be (	25. Was case referred to medical examiner?				26. Place of Dea		ne)	
	1 Yes 2 No Hospita	1 ☐ Inpatient 2 ☐ E	·		Nursing H	ome 5 🗆 Reside	ence 6 🗆 Ot	ther (Specify)
on	Natural 5 ☐ Pending	. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho	ow injury occu	irred
cat	2 Accident investigation 3 Suicide 6 Could not be	Diagrafiakan Athan	M		Yes 2□No	006 1		
ertif	4 ☐ Homicide determined 28e	Place of Injury - At horr building, etc. (Specify)	ne, iarm, street, fa	стогу, опісе		City or Town	treet and Num n, State)	nber or Rural Route Number,
Medical Certification: To	29a. Certifier  (Check only one)  (Check only one)  2 Medical Examiner: O ar	To the best of my know in the basis of examination and manner stated.	rledge, death occu on and/or investig	rred at the ti	me, date and place pinion, death occu	, and due to the c rred at the time, o	cause(s) and r late and place	manner as stated. e, and due to the cause(s)
Me	29b. Signature and title of certifier	الم		29c. Licens	e number	2	2-/6/6	ned (Month, Day, Year)
	30. Name and address of person who complete YOGESH VOHLA	ed cause of death (Item :		BR,	SALISB	ULY, M	D, 218	364.
te	31. Date filed (Month Day, Year)	32. Registrar's Signatu	J. Spark					•
ır	0 0 2003	harmy h	of page and					

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			For State Registrar		State of M	aryland / [		artmer <i>rtificat</i>				ental Hy	gien Reg. N	711119	04390
			Decedent's Name (First, Middle, Last)									2. Date of De	eath		3. Time of Death
	Physici /Medio		ROBERT LEWIS FINNEY						JANUARY 27 2						09:20 A M
	Examir			_	ive street and number				_		of Death		4	c. County of De	
ΤÉ	Funeral		Montgomery General Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday,						lney	If Unde	er 24 Hrs.	B. Date of Bi	rth	Montgo 9. B	irthplace (State or Foreign
	Director		220-18-		Sex 1 M 2 □ F		Yrs.	Months	Days	Hours		(Month, Di April		r) (	Country) Maryland
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Tow	n or Lo	cation							10d. Inside City Limits
	Maryla	tor	Md.	Montgo	nmerv			Spri	na						1 ☐ Yes 2 🗷 No
	th the	Director	10e. Street and Nur		JHCL Y	011	V C.1	10f. Zip					10g. C	citizen of What C	Country?
	ath wil	ral	14116 H	Meritage					0906					Jnited S	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine roughlo notified at ance.	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li><li>3 ☐ Widowed</li></ul>	ied 2 <b>K</b> Married 4 □ Divorced	12. Was Decedent Armed Forces' 1 XYes 2 If Yes, Give Year or Dates:	?		Was Dece If Yes, <b>s</b> pe 1 □Yes		lispanic O an, Mexica Specifi		city Yes or No ican, etc.)	0-	Black, Wh	nerican Indian, ite, etc. Vhite
5-0	72 ho natur	Completed	(Spec	15. Decedent's cify only highest of		16a	. Dece	dent's Usu	al Occup	ation during mo	ost of working	7	16b.	Kind of Busines	s/Industry
121	within iene. <b>than</b> "	Jumo	Elementary/Seco	-	College (1-4or	5+)		<i>во мот и</i> acher		d)	·			Educatio	~ m
d 2	filed I Hygir	Be Co	17. Father's Name	(First, Middle, La			re	acner		18. Moti	her's Name	(First, Middle			DII .
/lan	uld be Menta Irked Itlc ev	To B	Eugene	Stanley	y Finney				i	А	lice	Kell	У		
Maryland	1 and 2 should be filed i Health and Mental Hygi em 27 is marked other kther traumatic event, II		19a. Informant's Na	ame/Relationship Finney										or Town, State	
re,	ss 1 and of Health item 27		20a. Method of Dis			20b. Place o cemete	f Dispo	osition (Na	me of	ce)	Da	ite	20c.	Location - City of	or Town, State
ij	Pages ment of I			S ☐ Other (Spec	☐ Removal from State cify)	Metro				i	1/30,	/09	I	Alexandı	cia, Va.
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Fu	uneral Service Lic	W-B	arker	2	2. Name q Muri P. C	.el H	I. Ba	rber I	unera Layton		ome lle, Md.	. 20882
			23a. Part 1. Enter t shock, or hea Immediate Cause	art failure. List on	mplications that cause ly one cause on each	d the death. Do ine.									Approximate Interval Between Onset and Death
	Physician \/Medical		disease or condition resulting in death)	on	a. hron	s a consequence	of:	tru	cti	ur	Pie	lmon	an	Disc	ase
	Examiner		Cognoptically list on	nditions	b										
	led isit	Examiner	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or a	s a consequence	of):								
	be executed ician and burial-transit	xan	that initiated events resulting in death)	S	c Due to (or a	s a consequence	of):								
120				•	d										
K 687	ertifica ling ph e as th	Med	IF FEMALE:		237							-			
O. Box	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	23b. Was deceden in the past 12 1 ☐ Yes 2,↓ 9 ☐ Unknown	months?		e of pregnancy 2 ☐ Fetal death at time of death		☐ Ectopic ¡ ☐ Other <i>(s</i>		у				23d. Date of d Month	lelivery Day Year
ъ, С.	res that signed b be deta	by Pr	Part II. Other signi	ficant conditions	s contributing to death	but not resulting i	n the u	nderlying	cause giv	en in Parl	t I.	23e. Did	tobacco	use contribute	to the cause of death?
ord	w require s been siç should b	ted t	Cecal	Volv	ulus							10	Yes	2.☐No 3□	Probably 4 Unknown
of Vital Records,	ian: The law rrtificate has buttor, page 2 sh	Completed										24a. Was auto perfo 1 □ Yes	psy ormed?	prior to	
Vita	2 8 8	Be c	25. Was case referexaminer? 1 ☐ Yes 2	/	Hospital:	o 🗆 50/0			OA Oth	or:		(Check only			
	g Physical this leral dir	n: To	27. Manner of Deat	th	28a. Date of In	ient 2 ER/O	Time o		28c. Injur Wor	4 🗆 I				6 ☐ Other (S <sub>I</sub> ury occurred	pecify)
sion	Attending Isr death. ector: After by the funer	atio	1-⊡Natural 2	5 ☐ Pending investigat		ay, Year)	Injury	М		K? Yes 2[	□No				
Division	al or Att after de Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide	6  Could not determine	28e. Place of it	njury - At home, fa tc. <i>(Specify)</i>	arm, st	reet, factor	y, office		28	8f. Location ( City or To	(Street a wn, Sta	and Number or ite)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the best taminer: On the basis and manners	of examination a	e, dea nd/or ir	th occurred	d at the ti	me, date opinion, d	and place, a leath occurre	nd due to the	e cause , date a	(s) and manner nd place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and	Title of certifier	1/	Pa MA		29	c. Licens	e number	r		29d. E	ate signed (Mo	nth, Day, Year)  28 2007
	1-1	1	30. Name and add	ress of person wh	no completed cause of	death (Item 23a)	(Туре,	Print)	11	1		i	Jan	208	32 1
	Sta	ite_	AF We 31. Date filed (Mor	och vec	32. Regis	trags Signature	d	10000	# CI	DUET		The	Y	Man	dard
	Regist			JAN	3 0 2009 ▶	Deneva	A.	gra	aker						
		001													

			For State		Maryland / De	partment of	Health and N	-	•	
			State Registrar		C	ertificate of	Death		3. No. 200	9 04391
	Physic	ian	Decedent's Name (First, Mi	iddle, Last)				Date of Death     Month	Day Yea	3. Time of Death
al all	/Medi Examir		Patricia  4a. Facility Name (If not institu		nn er)	Holly 4b. City, Town,	or Location of Death	January	28, 2009 4c. County of De	
Ŧ			13508 Sentine				berland		Al	legany
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 👽 F	Age (In yrs. last birthd 77 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. B	irthplace (State or Foreign Country)
	Director		216-30-1856 Usual Residence of Decedent	Λ	77 Yrs			09/04/19	31 M	aryland
	yland		10a. State 10b. Cou	nty	10c. City, Town or	Location				10d. Inside City Limits
	Mar a-f st	양	MD	Allegany		Cumberla	nd			1 ☐ Yes 2 No
	or 28	Oire.	10e. Street and Number			10f. Zip Code		100	g. Citizen of What 0	Country?
	ath wi	ra I	13508 Senti	inel Lane, N.	E.		21502		USA	
	tems	nue	11. Marital Status	12. Was Deceder Armed Force	5?	<ol><li>Was Decedent of If Yes, specify Cult</li></ol>	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite_etc
36	s afte	γF	1 ☐ Never Married 2 🔀 M 3 ☐ Widowed 4 ☐ Divord	If Yes Give	ĮΝο	1 □Yes 2 🏋 No			Specify:	, 0
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show after Examinar insist be rediffed at	Completed by Funeral Director		dent's Education		ecedent's Usual Occu	pation	16	6b. Kind of Busines	Black
215	within 72 iene. <b>than "n</b> a	ple	(Specify only hig Elementary/Secondary (0-12	hest grade completed)	(G	ive kind of work done e. DO NOT use retire	during most of work	ing	Human Res	*
21	d with	5	12	4	· · · · .	dministrat	tor			nt Commission
nd	tal Hygi d other svent,	Be (	17. Father's Name (First, Midd	· _			18. Mother's Name	e (First, Middle, Ma	iden Surname)	
yla	should be fand Mental Band Men	မ	Earl	Oscar	Redma	n	Sarah	Nac	omi M	<i>l</i> ashington
Maryland	12 sh h and 7 is m traun		19a. Informant's Name/Relation				t and Number or Rur			
	1 and 2 Health tem 27 i	- 1	20a. Method of Disposition	ne Holly / H			nel Lane,			
Jo.	Pages nent of l ant: If Ite		1 ☐ Burial 2 ☑ Crematio	on 3 Removal from State	e cemetery, o	sposition (Name of crematory or other pla	ace)	}	c. Location - City o	•
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than 100 other traumatic event, Ite IN after Examinar In Item 100 other traumatic event, Ite IN after Examinar In Item 21 ones.		4 □ Donation 5 □ Other  21. Signature of Funeral Servi		Cumberl		cory  01/28		Cumberlan	
Ва	Depi Impo		21. Signature of 1 Green Servi	L Char			cur Street			Home, P.A.
			23a. Part 1. En er the disease	, or complications that caus	ed the death. Do not					21502 Approximate
	Physician		Immediate Cause (Final	ist only one cause on each	line.	s Dis		, , , , , , , , , , , , , , , , , , , ,	,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or a	as a consequence of):	2 612	8954			154840
	Examiner		0	b						
	₽ #	je	Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		s a consequence of:					
	ecute and frans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с						
760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or a	is a consequence of):					
687		dical		d						
Box (	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregnancy					
_	death atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date of d Month	elivery Day Year
P.O.	at the de by the tached	hysi	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknowr		o in or (apodiny) in				
	res that signed to be deta	by P	Part II. Other significant cond	litions contributing to death	but not resulting in the	e underlying cause gi	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ğ	w require s been sig should b	8		·				1 ☐ Yes	2. <b>1.</b> No 3□ F	Probably 4 Unknown
Records,	law re as be 2 sho	Completed						24a. Was an	24b. Were a	autopsy findings available
3	: The law cate has	<u>ا</u> ق						autopsy performe 1 □ Yes 2 🗓	d?   death?	completion of cause of s 2 □ No
Vital	sician: Th certificate rector, pag	Be (	25. Was case referred to medi examiner?				26. Place of Death		1010	3 2 110
of	Physic r this c ral dire	욘	1 ☐ Yes 2 ♣ No		tient 2 ☐ ER/Outpa	HEIN SELECT	her: 4  Nursing Ho	me 5 Residenc	ce 6 Other (Sp	ecify)
$\subseteq$	ding F h. After funera	ü	27. Manner of Death 1 Natural 5 □ Pen	ding 28a. Date of Ir	ijury 28b. Time <i>Day, Year)</i> Injur	y Wo	rk?	28d. Describe how	injury occurred	
isic	ttend death stor: the f	icat		stigation			Yes 2□No	_		
Division	or A after Direc	Certification:	4 ☐ Homicide dete	ermined 28e. Place of I building,	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 11 Certif	ying Physician: To the her	at of my knowledge de	eath occurred at the t	ime, date and place	and due to the co-	sa(s) and masses	ne etated
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medic one)	ying Physician: To the best al Examiner: On the basis and manner	of examination and/o	Investigation, in my	opinion, death occurr	ed at the time, date	e and place, and du	as stated. le to the cause(s)
	To the vithir comp	Me	29b. Signature and title of certi	THE 131	1	29c. Licens	se number	29d	. Date signed (Mon	th, Day, Year)
	2		1/1/	roms &	hundell	D3	35 <b>1</b> 35		January	28, 2009
			30. Name and address of person	on who completed cause of	deat (Item 23a) (Typ				J	,
	nes		Thomas	,		12 Seton D	rive, Cum	perland,	MD 2150	2
	Sta	ite	31. Date filed (Month, Day, Ye.	32. Regis	trar's Signature	1				
	Registr	ar	UNIT DU CO	Lenna	to be and					

				artment of Health and Mertificate of Death		ene 2009 04392
ſ	Physici /Medic		1. Decedent's Name (First, Middle, Last)  ROBERT WILSON HAINES		Date of Death Month     01	Day Year 22 2009 9:56 A. M
· marci	Examir		4a. Facility Name (If not institution, give street and number) 220 ARCH STREET	4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.     Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)
	Director		218-24-8420 Residence of Decedent		06/20/19	21 WEST VIRGINIA
	f show	ō	10a. State 10b. County 10c. City, Town or L  MD ALLEGANY CUMBE			10d. Inside City Limits 1tv Yes 2 □ No
	th the N or 28a-	Director	MD ALLEGANY CUMBE	CRLAND 10f. Zip Code	100	J. Citizen of What Country?
	s 23a		721 DALE AVENUE	21502		U.S.A.
ဖွ	or item	Funeral	1 Never Married 2 Married 1 X1Yes 2 No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
-003 -003	tural",	ed by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates: WWII  15. Decedent's Education 16a. Deci	1 □Yes 2 <b>X</b> No Specify:		Specify: WHITE
215	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exaction or must be treathed at	Completed	(Specify only highest grade completed)   (Give	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	α I	b. Kind of Business/Industry ELLY-SPRINGFIELD
d 21	filed wi Hygier other th		11 F ACT	ORY WORKER  18. Mother's Name		RE COMPANY
Maryland 21215-0036	should be filed and Mental Hyg s marked other umatic event,	To Be	WARD WILLIAM HAINES		BELLE S	, i
Mar	d 2 s th ar 7 is trau			ing Address (Street and Number or Rural  5 DALE AVENUE, CUM		
ore,	ges 1 and 2 t of Health If Item 27 or other tr			osition (Name of matory or other place)		c. Location - City or Town, State
Baltimore,	Pa men ant: ury		4 Donation 5 Other (Specify)	MEML. PARK 01/26	/2009	CUMBERLAND, MD
Ba	permit, Departi Import any inj once.		21. Signature of Funeral S rvig. Lio his e	2. Name and Address of Facility UPCHURCH FUNERAL 202 GREENE STREET	HOME, P.	A. LAND, MD 21502
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or	respiratory arrest	t, Approximate Interval Between Onset and Death
W. Carlo	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	RTERY NISEASE	h	Offset and Death
	Examiner	<u>ب</u>				
_	cuted id ansit	Examiner	Sequentially list conditions, if a y leading to hammelying cause. Enter Underlying Cause (Disease or injury that initiated events			
,09/	ficate be executed physician and s the burial-transit		resulting in death) Last C. Due to (or as a consequence of):			
289	certificate ding physise as the t	ledical	d			
Ď.	death e atter id for u	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
7.	that the		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Hecords,	requires seen sign hould be	ted b	LEUKEMIA		1 ☐ Yes	2 No 3 Probably 4 Ponknown
Š Ž	helawı ehasbı ge2sh	Completed by			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
VItal	clan: T ertificat ctor, pa	Be Co	25. Was case referred to medical examiner?	26. Place of Death	1 □ Yes 2	No 1 ☐ Yes 2 ☐ No
0	Physic r this corral dire		1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien  27. Manner of Death 28a. Date of Injury 28b. Time of	nt 3 DOA Other: 4 Nursing Hom		caretaker's e 6 DOther (Specify)residence
ion ion	ending eath. or: Afte he fune	Certification: To	1 ☑Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	3d. Describe how	injury occurred
DIVISION	or Atter de Directo	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	reet, factory, office	Bf. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s		29a. Certifier  (Check only one)  Medical Examiner: On the basis of examination and/or in an examination.	th occurred at the time, date and place, a	nd due to the caus	se(s) and manner as stated.
	Fo the within 2 Fo the comple:	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	5+		Hyidh , MD	D26907		01-23/2009
	NLD		30. Name and address of person who completed cause of death (Item 23a) (Type, H. Sidhu, M.D., 825 Bishop Walsh R	· ·	21502	
	Sta		31. Date filed (Month, Day, Year) 2009 33. Registrar's Signature	wed .	21302	
	Registra	ar	Only to Lots Company			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MABEL L. HUDSON /Medical Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10501G Social Security Number **Funeral** 8 Date of Birth (Month, Day, If Under 1 Year (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F Months Days Hours Min. **Director** 222-28-1990 84 6-1-1924 MARYLAND Usual Residence of Decedent 10a. State 10b. County or 28a-f show 10c. City, Town or Location other than "natural", or items 23a or 28a-f showent, the Midical Examinar must be notified at 10d. Inside City Limits Director DELAWARE SUSSEX **DAGSBORO** 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32295 FALLING POINT ROAD Funeral 19939 US 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☑ No Specify: WHITE Be Completed Pages 1 and 2 should be filed within 72 h nent of Health and Mental Hygiene. ant: If item 27 is marked other than "nat 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 2121 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA MANAGER FOOD SERVICE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PHILLIP STEELE ၉ SADIE JUSTICE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID ALLEN MITCHELL/GRANDSON 32298 FALLING POINT RD, DAGSBORO, DE. 19939 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of I Important: If ite any injury or ot 20c. Location - City or Town, State 1X Burial 2 Creme 3 Removal from State 4 Donation 5 Other Specify) GEORGE'S CEMETERY 2-2-09 CLARKSVILLE, DELAWARE 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE, 19945 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAUR RRNAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ng physician and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant for 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy cate has been signed by the page 2 should be detached 5 ☐ Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown certificate has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 1 □Yes 2 ₽ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 4No Other: 4 Nursing Home 5 Residence (Dother (Specify) HOSPI CA 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Hospital or Attending Natural 28d. Describe how injury occurred 5 Pending death. i Director: d in by the f 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hou

To the Fune
completely fi Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DN6 eituran war Que Box 1773 Stay surf uno 21802 ASTAL

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 03

32. Registrar's Signature

			1 - For Stata Registrar	State of Maryla	nd / Depart <i>Certi</i> i	ment of H	lealth and Death		iene2 () ()	9 04394
	Physici /Medio		Decedent's Name (First, Middle, Last	Frances Mae I	Houser			2. Date of Deat Month Februar	Day Y	ear 3:00 AMM
1	Examin		4a. Fecility Name (If not institution, give				Location of Deat	th	4c. County of	
	Funeral Director		Julia Manor Healt 5. Social Security Number 214-28-5343		s. last birthday)	lagersto f Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	gton Birthplace (State or Foreign Country) Marvland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Locat	ion				10d. Inside City Limits
	Maryi	tor	MD Washing	ton	harpsbur	n				1 ☐ Yes 2 💢 No
	or 28	Director	10e. Street and Number	<u> </u>	nai pavar	10f. Zip Code		1	0g. Citizen of Wha	at Country?
	eeth v		1803 Back Road	12. Was Decedent Ever in	IIS 13 Wa	21782		Specify Yes or No-	USA 14 Bace	American Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mental Hygiene. Depertment of Heath and Mental Hygiene.  Brootchent: If Item 27 is marked other than "natural; or items 23a or 28e-f ehow eny injury or other traumatic event, the Madical Examinar must be notified a once.	by Funeral	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 XNo If Yes, Give Year or Dates:	lf Y	es, specify Cuba	Specify:	to Rican, etc.)		White, etc.
21215-0036	72 ho	Completed by	15. Decedent's Ec (Specify only highest gra	lucation de completed)	(Give kin	t's Usual Occupa d of work done of	during most of wo	rking	16b. Kind of Busin	ness/Industry
7	within ene. then	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	Shoe (	NOT use retired	1)		Shoo Man	ufacturing
کر 20	other	0	17. Father's Name (First, Middle, Last)		31106	ucter	18. Mother's Na	me (First, Middle, I		urac cur riig
ylar	nould be d Mental narked o natic eve	ToB	Raymond Waters				Charle	tte Knig	ht	
Maryland	d 2 sho h and 7 ls m traum		19a. Informant's Name/Relationship (		19b. Mailing	Address (Street a	and Number or R	ural Route Number	, City or Town, Sta	ate, Zip Code)
ნ	Healt Healt tem 2		Peggy Ecton - Da 20a. Method of Disposition	ıghter 20b	. Place of Dispositi	darpers on (Name of	Ferry Re	_ Shar	psburg 20c. Location - Cir	MD 21782 ty or Town, State
e E	Pages nent of I int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Inemoval num State	cemetery, cremat amples Ma		i i	11/09		ra. MD
Baltimore,	Depentit. Depentit Importa eny inju		21. Signature of Funeral Service Licer	see	22. N	ame and Addres	ss of Facility Ea		encer &	Norton Funeral
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	ath. Do not enter t	the mode of dying	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conse	equence of):	roma	len			1/2-1 HW
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	cuted	Examiner	that initiated events	. Dimile	is Mell	clus				YRS
8760,	cate be executed bysicien and the burial-transit	EX3	resulting in death) Last	Due to (or as a conse		· · · · · · · · · · · ·	_			
687	ficate physi s the t	edical		a Hovance	a ov	Mineral Company	-			YRS.
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. T death. sctor: After this certificate has been signed by the attending physicien and ector: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 □Ed	etopic pregnancy ther (specify)			23d. Date of Month	
<u>.</u> آ	that the seed by detac	y Ph	Part II. Other significant conditions of	ontributing to death but not re	esulting in the unde	rlying cause give	en in Part I.	23e. Did tob	pacco use contribu	ute to the cause of death?
rds	w requires been sign should be	ed b						1 □ Ye	s 2 □ No 3	☐ Probably 4 🕅 Unknown
Records,	lawre les bee	Completed						24a. Was a autops	n 24b. We	re autopsy findings available or to completion of cause of
<u>교</u>	ician: The lav certificete hes ector, page 2							perform	ned? dea	th? Yes 2 V No
5	siciar s certif irecto	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	oC pos Othe	00	ath (Check only on		(0.14)
o c	g Phy terthis neral c	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)		28c. Injun Work		dome 5 Reside	w injury occurred	
Sior	tendin eath. or: Af the fur	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	n	in qui y		Yes 2 □ No			
Ż.	5 # # C	Certification:	4 Homicide determined	building, etc. (Spec	cify)			City or Town	n, State)	or Rural Route Number,
	To the Hospital within 24 hours e To the Funerel Completely filled is	edical	29a. Certifier 1 X Cartifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, death or nation and/or inves	ccurred at the tim stigation, in my op	ne, date and place pinion, death occ	e, and due to the ca urred at the time, d	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)
	To the To the Comp	W	29b. Signature and title of certifier			29c. License	e number		9d. Date signed (	_
	7		Nedue	completed serves of death (**	am 22c) (% - 5 :		46561		07.00	7.2009
	(4)		30. Name and address of person who GIFA DAM QAD 11	U 1190 MT	em 23a) (Type, Pri	ROAD	HAGENST	DWN M	0 21	740
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	11.	. 4.1	,5			

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State of Maryland / Department of Health and Mental Hygiene.

			1 - State Registrar	State of Mary	Co	rtificate of	Dooth	ivientai Hy	ygiene	09 04395
H			Decedent's Name (First, Middle, La.	st)		runcate or	Death	2. Date of D	110g. 1101-	
	Physic /Medi		Howard Donald Hood	i				Month	Day	Year 3. Time of Death
	Exami		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Dea	Februa	ry 7, 20 4c. County	
-pade			Glade Valley Nurs			Walkersv			Freder	rick
	Funeral Director			ĬM 2□F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr. Hours Min	. (Month, D	rth ay, Year)	Birthplace (State or Foreign Country)
	ъ		Usual Residence of Decedent		86 Yrs.			Nov. 1	4, 1922	Maryland
	arylar show	_	10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	he Ma 28a-f	Director	Maryland Frederick	K Mo	ount Air	У				1 X Yes 2 No
	a or	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	ns 23	Funeral	601 Prospect Stree	12. Was Decedent Ever i	-11C 140 1	21771			USA	
9	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be retified at	Ę	1 Never Married 2 Married	Armed Forces? 1 □Yes 2 🕅 No	10.5.	Was Decedent of Hi f Yes, specify Cuba	Ispanic Origin? ( In, Mexican, Puer	Specify Yes or No rto Rican, etc.)	D- 14. Race Black	e - American Indian, k, White, etc.
5-0036	ours a	db	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I∐Yes 2XINo	Specify:		Specify:	White
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yland	ald be dental rked o	To B	Howard Ephrain Hoo	d					Maiden Surname	9)
Mary	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Pedical Examiner must be retified at		19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street a		IN) Runk]		2644 75 O 40
₹. 2	and 2 ealth n 27 i		Eleanor Hood, wife			rospect R				•
ore	ges 1 t of H if iter or off		20a. Method of Disposition 1 ፟ Burial 2 □ Cremation 3 □	201	b. Place of Dispos	sition (Name of atory or other place		Pate 72009	20c. Location - (	nd 21771 Dity or Town, State
baltimore	t. Pac rtmen rtant: njury		4 □ Donation 5 □ Other (Specify	) P	rospect	Methodis	t Cemete	rv	Mount Ai	ry, Maryland
D D	permit. Pages 1 and 2 should b Department of Health and Menit Important: If item 27 is marked any Injury or other traumatic e once.		21. Signature of Funeral Service Licens	See .	22.	Name and Addres	s of FacilitMo1	esworth-	-Williams	Funeral Home
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•	Physician /Medical		disease or condition resulting in death)	a. Hoyle )	knosis					Onset and Death MONTHS
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	rtificate be ng physick as the bur	fedical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a cons	equence of): equence of): gnancy etal death 3 □	Ectopic pregnancy	1		23d. Date	of delivery
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				artment of Health and Mental Hygiene rtificate of Death Reg. No. 2009 04396
	Dhysis		1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medi		Wade Doran Hall	January 26, 2009 10:25P M
4	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
70		×	Riderwood Village  5. Social Security Number   6. Sex   7. Age (In vrs. last birthday)	Silver Spring Montgomery  If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Foreign)
	Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   500-20-4350   1	Months Days Hours Min. (Month, Day, Year)
			Usual Residence of Decedent	Dec.7, 1925 Missouri
	rylan show	_	10a. State 10b. County 10c. City, Town or Lo	Tod. Inside Oily Entire
	e Ma 8a-f	cto	Maryland   Montgomery   Silver Spr	ring 1 □Yes 2₺No
	with th	ä	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinar must be notified at	Funeral Director	3114 Gracefield Road WC209  11. Marital Status  12. Was Decedent Ever in U.S. 13.	20904 USA
(0	fter d r item iner	F	11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No WUII	Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
036	al",o	þ	3 ☐ Widowed 4 ☐ Divorced	1□Yes 2色No Specify: Specify: White
21215-0036	72 ho natur ficel	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation 16b. Kind of Business/Industry
121	ithin ne. <b>han</b> "	Ig III	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)
2	iled w Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	national Affairs Officer US State Department
ano	d be f ental red o	Be C	Benjamin C. Hall	18. Mother's Name (First, Middle, Maiden Surname)  Maude Pearl Jones
ary	shoul nd M mari	은		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Σ	alth a		0 77 70 0 77 (-	May Lane Edgewater, Maryland 21037
ore	es 1 a of He item	-	20a. Method of Disposition 20b. Place of Dispo	sition (Name of natory or other place)  Date 20c. Location - City or Town, State
<u><u>Ë</u></u>	Page ment ant: It ury o		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donatiop 5 □ Other (Specify)  Kalas Ci	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Examinat must be notified at once.		21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility George P. Kalas Funeral Home
=	<u></u> <u>0</u> 0 = <u>6</u> 0		My or alm.	973 Solomons Island Rd. Edgewater, Maryland21037
			23a. Part 1 Inter the disease, or complication of all aused the death. Do not ent shock, or heart failure. Lift only one cause on each line.	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Parkinson's Dis	Sease Onset and Death
	Examiner		Due to (or as a consequence of):	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury	
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events . C.	
0,	e execu ian and ırial-trar	Ë	resulting in death) Last Due to (or as a consequence of):	
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9 x	eath certific attending p for use as	/Mec	IF FEMALE:	
Вох	atten for us	ian	A December of death = E	Ectopic pregnancy 23d. Date of delivery  Month Day Year
0	the d y the iched	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 L 9 Unknown 9 Unknown	Other (specify)
٠ <u>,</u>	uires that the de signed by the a d be detached		Part II. Other significant conditions contributing to death but not resulting in the un	
Records,	w requires s been sig should be	Completed by	Coronary Artery Disease, Osteopeni	a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown
၁၁ခ	e law re has be	plet	Benign Prostatic Hypertrophy	24a. Was an 24b. Were autopsy findings available
H	sician: The l certificate ha rector, page	ĕ		autopsy prior to completion of cause of performed? death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
Vital	ician: The certificate ector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
of	Physi r this c ral dire	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	The same of the same of the same (Specify)
no	ding F h. After funera	io	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury	Work?
Division	Attender deatl	fical	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	12100 2310
Ö	al or Attendir s after death. I Director: Af d in by the fur	Certification: To	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ospita hours unera ly fille		29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or in	n occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funera	Medical	one) Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			* * achille M. Wegion MD	D44156 1/27/2009
	14/1/		30. Name and address of person who completed cause of death (Item 23a) (Type, I	
	Sta	te	31. Date filed (Month, Day, Year)  JAN 2 9 2009  JAN 2 9 2009  JAN 2 9 2009	seld Rd Silver Spring ND 20904
	Registr		JAN 2 9 2009 Janua B. of	barles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04397 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year William George Hickle 02 08 09 0700 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Yea Months 1 M 2 F Director 220-58-0601 57 Mar 6. 1951 MD Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location show 10d. Inside City Limits s 23a or 28a-f show WV Mineral Ridgeley Director 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 2 Box 248 26753 USA Funeral 7 Is marked other than "natural", or items traumatic event, the Wedical Exp. of the Pro-12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or ite Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 □ NoX Specify þ If Yes, Give Year or Dates: Vietnam 3 Widowed 4 Noivorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tower operator CSX Railroad permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George William Hickle, Sr Goldie Layton Hickle ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Plessinger sister 1954 Bradshaw Road Warfordsburg PA 17267 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Barial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 2/9/2009 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licente 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, of shock, or heart failure. List combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in eath) CARCINOMA LUNG Extensive CELL **Physician** N9200 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) requires that the death certificate be execut burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending property of the second IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s 24a Was an autopsy performed? Yes 2 1 No director, page certificate Division of Vital 1 ☐ Yes 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check onl one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Registrar's Signature

Clineur

DHMH 17 Rev 1/2001

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Dh

29c. License number

ON DR

29d. Date signed (Month, Day, Year) Fel 9, 200

mp alson

		1	For State Registrar	T TOU	State	of Maryl	and / Dep <i>Ce</i>	artmen rtificate					giene Reg. No.	009	04398
ă ·	Physici		1. Decedent's Nam									2. Date of De Month	Day	Year	3. Time of Death 1:35 p M
	/Medic	al	Jean G	. Irvin		umber)		4b. City,	Town, or	Location of	of Death	Januar		L, 2009 County of Deat	
	Examin	er	Lorien 1						Colu	mbia			F	Howard	
é	Funeral		5. Social Security N	Number	6. Sex 1 ☐ M 2 🔀 F		yrs. last birthday,	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)		hplace (State or Foreign untry)
*	Director		579-20-31 Usual Residence o			85	Yrs.					12/31/	1923	Was	hington D.C.
	yland sow		10a. State	10b. County		10c	. City, Town or L								10d. Inside City Limits
	a-f el	ctor	Md.	Howa	rd 		Colum	nbia							1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Nu					10f. Zip					-	en of What Co	ountry?
	ss 23s		8955 Que	een Mar		cedent Ever i	in U.S. 13.		.045 dent of Hi	spanic Ori	igin? (Sp	ecify Yes or No		JSA 4. Race - Ame	ncan Indian,
(0	r item	Funeral	1 Never Mari	ried 2 Marr	Armed I ned 1 ☐ Yes	Forces?						ecify Yes or No Rican, etc.)		Black, Whit	
93	ours a	d by	3X Widowed	4 Divorced	If Yes, C Year or			1 🗌 Yes		Specify:				Specify: Wh	
5	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f ehow than Madical Examinar must be motified at	Completed	(Spe	15. Decedent cify only highes	t's Education st grade completed	1)	16a. Dece (Give	edent's Usua e kind of wo DO NOT u	al Occupa rk done c se retired	ation d <i>uring</i> mos ()	it of work	ring	16b. Kin	nd of Business/	Industry
12	within iene. r than	фшо	Elementary/Second 12yrs	ondary (0·12)	Coilege	(1-4or 5+)	Cle			,			C&I	Telep	hone
פַ	be filed ital Hygir d other event, I	BeC	17. Father's Name	(First, Middle,	Last)					18. Moth	er's Nam	e (First, Middle			
ylaı	should band Ments marked umatice	70	Allen Ha									ude Sch			
Maryland 21215-0036	12 sh h and 7 is m traum	Ì	19a. Informant's N Lynda II									al Route Numb Columbi			Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any njury or other traumatic event, the Madical Examination at the multipart at ange.		20a. Method of Dis			20	b. Place of Disp				_	Date		cation · City or	Town, State
<u>o</u> E	Pages nent of int: If it iry or o			☐Cremation 5☐Other (S	3 □Removal from pecify)	n State	arklawn				2/4/:	2009	Rock	wille,	Md.
Baltimore,	permit. Pages Depertment of Important: If it any injury or o	2 1	21. Signature of F			_	2	2. Name ar	d Addres	s of Facili	Mar:	ry H.Wi	tzke'	's Fami	ly F.H.Inc.
ω _	89559		Umi	du r	amali									t City	,Md. 21043
8					complications that only one cause or	t caused the o	death. Do not er	nter the mod	de of dyin C	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause disease or conditi resulting in death)	on	a	me	uno	nu							days
	Examiner				Jan.	O (or as a cor	rsequence of):	ni	(a)	tov	_	faile	IVE	2	morths
*		Je	Sequentially list of if any, leading to it cause. Enter Und Cause (Disease o	onditions, mmediate	Due t	o (or as a cor	nsequence of):	1	1 /	101	1	1001			
	cuted nd transit	Examiner	Cause (Disease of that initiated event resulting in death)	lS	· pu	mo	nary	7	5 V	20	is				years
760,	be executed sician and burial-transit	cal Ex	resulting in death)	Last	Due	o (or as a cor	nsequence of								l
687	2 2 9				d										
Box (	law requires that the death certificate be exas been signed by the attending physician 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was deceder	nt pregnant		outcome of pr		□Ectopic p		,			2	3d. Date of de	•
	that the death ed by the atte detached for	sicia	in the past 12	No		gnant at time		Other (s			-			Month	Day Year
P.0.	d by the	Phy	9 Unknow		ons contributing to		t resulting in the	underlying (	ralise div	en in Part	1	23e. Did	lobacco u	se contribute to	the cause of death?
ds,	signed be det	d by	dusph	2010			ary	hus	est	ens	do	10			robably 4 □Uπknown
Records,	w requir been si should	iete	NinL	000	2 /	10×1	alcen	110	do	ino	itio	24a. Was	an	24b. Were a	utopsy findings available
	The lay	Completed	OI V		, ,	perc	n all	11 -	7	110	0-1	auto perf	psy ormed? 2 No	prior to death?	completion of cause of
Vital		BeC	25. Was case refe examiner?	erred to medica	ı						e of Dea	th (Check only			
of V	S S	2	1   Yes 2	No			2 ER/Outpatio			4×N	ursing H	ome 5 Res	•		ocify)
UC C	Jing P	ion:	27. Manner of Dea	ath 5 🗌 Pendir investi	ng (M	te of Injury onth, Day Yea	ar) 28b. Time Injury		28c. Injur Wor	yat k? Yes 2.[	1No	28d. Describe	now injury	y occurred	
Division	Attending r death. ector: After by the funer	fica	Accident Suicide	6 Could	not be 28e. Pla		At home, farm, s					28f. Location	Street and	d Number or R	ural Route Number,
Ö	s after al Dire	Certification:	4 🗌 Homicide		Du	iding, etc. (S	рөслу)					City of To	wn, State,	,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)		ng Physician: To Examiner: On the and m										
_	To the within To the compl	Me	29b. Signature an	d title of certifie	or	11	2	29	c. Licens	e number	10			e signed (Mon	
7;	10		//	100		-	/			D	419	55		31:	2004
(5	100	1	Celse	ca E	200 M	6	3346	Print)	la	ne	#10	3 6/	uml	bial	2009 1P2104)
	St Regist	ate rar	31. Date filed (Ma	FEB 0	2 2009	. Begistrar's	Signature 4	barks	1						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Judy Mae Juanita 01 09 0810 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 K F 213-22-4173 10/03/1924 Director Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Evandren must be notified at Director 1 XYes 2 No MD Allegany Cumber land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with t and Mental Hygiene.
Is marked other than "natural", or items 23a or 2 21502 307 Helen Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fibers 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental F Bugg Edna Mae Hersh Theodore Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Janice Christie Lindsey / Daughter 307 Helen Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park | 01/29/2009 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic **Physiclan** 6months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ng physician and as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an autopsy 2 **X**No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. 28d. Describe how injury occurred After t Injury at Work? 1 Natural
2 Accident 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) worsock Shi MD 00055325 Jan 26, 2009 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALSH RD Cumberland MD 2/502 MLS MO 925 BISHOP WONSOCK SHIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 27 2009 Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

Division of Vital Records.

09-01007 William Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 04400 1- For State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death **Medical Examiner** 1123 hrs William A. Jones <del>Sr</del> February 3, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore N/A 5. Social Security Number 6. Sex **Funeral** If Under 1 Year If Under 24Hrs. 8: Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Min 213-36-2072 1 X M 2 68 Yrs Feb 12 1940 cMan yland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Lothian Yes 2 X No after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Ark Rd. 20711 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces' White, etc. Never Married 2 X Married 2 X No Yes Widowed If Yes, Give Year Divorced Yes 2 X No specify: Specify: Black \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Southern Senior Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked offuer that or other traumatic event, the Medica 12th 0 Engineer Hiah School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Jones Rebecca Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Ida V. Jones(Wife) Ark Rd. Lothian, Md. 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) Burial 2 X Cremation 3 Removal from State Department o Metro Crematory 2-6-09 4 Donation 5 Other *Specify:*21. Signature of Funeral Service Licensee Baltimore, Md. 2級Mm: anR智健等色 Faglity Sons Mortuary, P.A. Zavry & Keese MOS/83 | 021 WESC SC. This property of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 821 West St. Annapolis, Md. 21401 Physician Approximate Interval Between Onset and /Medical Death Immediate Cause (Final disease Hypertensive atherosclerotic cardiovascular disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X AMENDED #1,23a,PII,27,perME, g889 3/9/09 TT X UNPENDED attending physician or use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Day Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) detached for Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Diabetes mellitus, renal disease Completed has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 performed? death? ✓ Yes 2

Box 68760 P.O. Records, certificate Hospital or Attending Physician: Division of Vital this After Funeral Director:

Be the filled in by

Medical

To the l

25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 / Inpatient 2 Other: ER/Outpatient 3 DOA Residence 6 1 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending Yes 2 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide

29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 21 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

31. Date filed (Month, Day, Year, State Registrar FFR 09

Pamela E. Southall, MD

Registrar's Signature

February 4, 2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate	of Death		R	eg. No.	JU9 U44C
Physic		1. Decedent's Name (First, Midd	le,Last)				2. Date of Dea	ith	3. Time of Death
ledical Exam	inei	Garry L. Jenki	ns Jr.				Month February	8, 2009 Year	0300 hrs
1		4a. Facility Name (if not institution	,		4b. City, Town	, or Location of Dea		4c. County of	
		Anne Arundel Medica	l Center		Annapoli	S		Anne Aru	ındel
Funeral		5. Social Security Number	6. Sex 7. Age (I	n yrs. last birthday	) If Under 1	Year If Under 24H	Irs. 8. Date of Bi	rth(MM/DD/YYYY)	9. Birthplace (State or
Director		220-72-1148	1XM 2F	46	Yrs. Months [	Days Hours M	in. 10/19	/1962	Foreign Country) MD
		Usual Residence of Decedent					1	, 2702	77 110
any		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
* * .	_	MD Anne	Arundel		Arı	nold			1 Yes 2 X No
Maryland 28a-f show d at once.	용	10e. Street and Number			10f. Zip Cod			On Oldinan of Min	
e Ma or 28	Director	1016 DCA D1 1					11	0g. Citizen of Wha	at Country?
ith the Maryland 23a or 28a-f sho notified at once.						1012		US	<u>A</u>
th wi ems	Funeral	11. Marital Status  1 Never Married 2 X M.	12. Was Decedent Event Armed Forces?	er in U.S. 13.		Hispanic Origin? ( ban, Mexican, Puei		14. Race - White,	American Indian, Black,
r dea or it mus	Ē		1 Yes 2X	No			no raican, cic.)	vviiite,	etc.
afte raf", iner	þ		orced If Yes, Give Year or Dates:		Yes 2 X	No specify:		Specify:	White
nours natm		15. Decedent's Education (Spe-				pation (Give kind of life. DO NOT use re		16b. Kind of Bus	iness/Industry
6 an ", cal F	Completed	Elementary/Secondary (0-12)			g most or working	ille. DO NOT use i	etired)		
vithir ene.	Ę		3	Pr	oject Ma	ınager		H	VAC
215-0036 be filed within 7 nal Hygiene. -ked other than ent, hr M dica					-	18.Mother's Nar	me (First, Middle, I	Maiden Sumame)	
2121 uld be fil Mental F marked	Be	Garry L. Jenki	as Sr.			Carol :	L. Spoon		
ID 21215-00% should be filed with and Mental Hygiene 7 is marked other that	To	19a. Informant's Name/Relations	, , , , ,	19b. Ma	iling Address (S	treet and Number o	r Rural Route Nur	nber, City or Town	, State, Zip Code)
s, MD 21215-0036 and 2 should be filed within 72 about be filed within 72 feet and Merchan team 27 is marked other than transmite event, the Medical		Virginia Jenki	ns Spouse	121	6 B&A B1	vd. Arn	old, MD	21012	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Itelath and Manhall Hygiers, the mir. If Item 27 is marked other than "natural", or items 23a or 28a-f she ure. If them 17 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once		20a. Method of Disposition			position (Name of	cemetery,	Date	20c. Location - 0	City or Town, State
Baltimore, permit Pages I ar Department of Hee mportant: If ite	,		Removal from State		r other place)			4	
Itin iit P artme ortan	-	4 Donation 5 Other Sp 21. Signature of Funeral Service		Atlantic	Cremato	ry 2	/11/2009	Glen Bu	rnie. MD
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other tramm		Bah A	all		2. Name and Addi	ess of Facility Har	rdesty Fi	uneral Ho	ome, P.A.
Physician		23a. Part I. Enter the disease, or	complications that caused the	- 11	/ Kidoel	V AVA	Annanolii	- MD 21/	501
/Medical		failure. List only one cause	on each line.		er the mode or dyr	ng, such as cardiac	or respiratory arr	est, snock, or near	t Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)							Death
		or condition resulting in death)	Due to (or as a conseque	ence of):					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
	ij	cause. Enter Underlying Cause	c	51100 017.					
=	Examiner	events resulting in death) Last	Due to (or as a conseque	ence of):					
scuted and trans			d						
3760, Ificate be executed g physician and s the burial - transi	n/Medical	X UNPENDED	X AMENDED #1 a	s noted,	23a,27,	perME, g	390 4/270	)9 TT	
8760, iificate be ex ng physician	Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of d	eliven
687 certific ading p	au/	23b. Was decedent pregnant in th past 12 months?	e 1 Live birth	2	Fetal death	3 Ectopic preg	nancy	Month	Day Year
Box 68  e death cert  the attendin  ed for use a	<u>::</u>		4 Pregnant at time	e of death 5	Other (Specify)			4	
the de	Physicia		g Unknown						
cords, P.O. Box 68  law requires that the death certification has been signed by the attending 2 should be detached for use as:	by P	Part II. Other significant conditi	ons contributing to death bu	t not resulting in th	ne underlying caus	e given in Part I.	23e. Did to	bacco use contribi	ute to the cause of death?
sign Ibe of	힣						1 Yes	2 🗸 No 3	Probably 4 Unknown
Division of Vital Records, at lot Attending Physician: The law requires after death.  In Director: After this certificate has been select in by the funeral director, page 2 should to	Completed						24a. Was a		ere autopsy findings available
e law e has ge 2 s	립						autop perfor	med? dea	or to completion of cause of ath?
Rec: The liftcate h		05 Was assessful to the first					1 🗸 Yes	2 No 1	Yes 2 No
1 of Vital Reco ling Physician: The law After this certificate has funeral director, page 2 si	Be	25. Was case referred to medical examiner?	[Hospital:			oce of Death (Chec			
Phys rathis	의	1 ✓ Yes 2 No	i inpatient	2 🗸 ER/Outpati		-			Other:
J O Ling	崩	27. Manner of Death  1 X Natural 5 Pendi	28a. Date of Injury (Month, Day, Year)	28b. Time	· · ·   -	njury at Work?	28d. Describe h	now injury occurred	
ttenc death stor:	lä:	Pendi	ing tigation		1	Yes 2 No			
IVIS or A after Direc	鮨		not be 28e. Place of Injury	- At home, farm, s	treet, factory, offic	e building, etc.			or Rural Route Number, City
eral filled	Certification:	4 Homicide determ	mined (Specify)				or Town, S	tate)	
Hos 24 h Fun etely	<u>a</u>	29a. Certifier (Check only 1 Certifying Ph	ysician: To the best of my kn	owledge, death oc	curred at the time,	date and place, an	id due to the cause	e(s) and manner a	s stated.
Division  To the Hospital or Attendia within 24 hours after death To the Funeral Director: A completely filled in by the fu	Medical	one) 2 Medical Exam	miner:On the basis of examina and manner stated.	tion and/or investi	gation, in my opini	on, death occurred	at the time, date a	and place, and due	e to the cause(s)
F 3 F 8	ž.	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
		May mis Dr	ne lk. pp		0.0	C.M.E.		February 8, 2	
COM	-	30. Name and address of person v	who completed course of death	(Itam 22a)					
110		Margarita Korell MD.	who completed cause of death Assistant Medical Exa	,	Penn Street	Baltimore, MD	21201		
C.	ate	•					21201		
St Regist	rar	31. Date filed (Month, Day, Year) FEB 10	2009 Peneur		arked				

State

29b. Signature and title of certifie

Melissa Brassell, MD

FFR

OCME

31. Date filed (Month, Day, Year)

Fo the

Registrar DHMH 17 Rev 1/2001 OCME 2006

**ORIGINAL** 

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

arke

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 3, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Reg. No. 20 04403 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 0. CI 19 2009 1950 P /Medical January. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany 701 Fourth Street, Apt 220 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖫 F Yrs. 75 215-34-4767 **Director** 02/07/1933 Pen<u>nsylvania</u> Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lijury or other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva., for contact to other traumatic event, the Walter Eva. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Fourth Street, Apt 220 21502 USA death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Housekeeping Hote] 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Webster Smith Mason Edna Trene Sowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Kile / Daughter 175 Lost Run Road, Clearville, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 01/20/2009 Cumberland, MD Signature of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Approximate Interval Between Onset and Death 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician UDDEN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day P.0. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe this certificate 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 100 Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the H within 24 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0054004 January 20, 2009 amou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** <u>Olinda Marie Kidwell</u> 24, 2009 1:45 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Frostburg Nursing & Rehab Center Frostburg Allegany If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F 215-10-4472 91 January 29, 1917 Director Maryland Usual Residence of Deceden d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It am "matural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Taylor Street U.S.A. 21532-Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coning Department fibers manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Salvatore Mele Rosina Rosario Ruffo ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Michael Kidwell Son Virginia 22630-110 Grebe Drive Front Royal Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If Iter
any Injury or oth 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) January 27, 2009 Sunset Memorial Park Cumberland Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John Je. wurs Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRUNIC OBSTRUCTIVE LUNG DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examine attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performe certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 1 Inpatient 2 ER/Outpatient 3 DOA P this After thi 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, To the Hospital or Attending Physician:

The law requires that the death certificate be executed

P.O. Box 68760,

Baltimore, Maryland 21215-0036

4 MRS

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Heille

Sidhu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

02690

29c. License number

925 Bishop Walsh Rd Cumberland, Mol

29d. Date signed (Month, Day, Year)

			1 - State of Maryland / State of Maryland / Registrar	Depa Cer	rtment of He tificate of D	ealth and M <i>Peath</i>		ne <sub>No.</sub> 2009	04405
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Dorothy Kuhrmann					3,2009	11:03a M
	Examir	er	4a. Facility Name (If not institution, give street and number)	İ	4b. City, Town, or I			4c. County of Death	
1		Н	10204 Coolfont Crossing  5. Social Security Number 6. Sex 7. Age (In yrs. last by the security Number 10. Sex 10. Age (In yrs. last by the security Number 10. Sex 10. Age (In yrs. last by the security Number 10. Sex 10. Age (In yrs. last by the sex 10. Age (In yrs	nirthdau)	New Mark	lf Under 24 Hrs.	8. Date of Birth	Frederick	alone (Ctate or Foreign
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	the Maryland r 28a-f show rottfied at	ior	Maryland Frederick New Ma	rkot					1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number	IIKEL	10f. Zip Code		10g.	Citizen of What Cour	ntry?
	th wit	'al	10204 Coolfont Crossing		21774		Un	ited State	es
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe . Mexican, Puerto F	cify Yes or No-	14. Race - Americ	
Maryland 21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Exambar must be routified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X ☐ No If Yes, Give Year or Dates:			Specify:		Specify: White	
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anc	I be filed intal Hyg ed other event,	Be				18. Mother's Name		ien Surname)	
7	hould nd Me mark matic	မှ	Raymond Wisnom  19a. Informant's Name/Relationship (Type. Print)  15	h Mailin		Irene Kar		tv or Town. State. Zir	Code
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service Licensee					eral Homes	
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Records,	law re as be 2 sho	Completed by					24a. Was an	24b. Were auto	psy findings available
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∑	or A after Direct in by	irtif	4 Homicide determined 28e. Place of njury - At home, f		1	2	St. Location (Street City or Town, St 5204 Ceo	and Number or Rura	I Route Number,
_	spital ours beral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge		OCCUPRED at the time			font (rossil	16 New Market
	e Hos 24 h e Fur letely	Medical	(Check only one)  Medical Examiner: On the basis of examination a and manner stated.	and/or inv	estigation, in my opi	nion, death occurre	d at the time, date	and place, and due to	the cause(s)
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Me	29b. Signature and title of certifier		29c. License r	number	29d.	Date signed (Month,	Day, Year)
			Almy Kalinas MT TMI		D37	1197	Ja	nuary 2	9. 2009
	6		30. Name and address of person who completed cause of death (Item 23a)	) (Type, P	-1-4) -				/
	()		Alan Kohrer MDDME 15Wes	t7	the Stra	et Fre	derick	MD	21701
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	h	1	()	7		
<u> </u>	Registr	ır	JAN 3 U 2009 > Eleneura	A.	granks				

Baltimore, Maryland 21215-0036

Physi

	Division of Vital Records, P.O. Box 68760,
+	To the Hospital or Attending Physician: The law requires that the death certificate be executed
1	within 24 hours after death.
	To the Funeral Director: After this certificate has been signed by the attending physician and
	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		For State Registrar		State o	f Maryland		artment of F ertificate of		Mental Hy	giene Reg. No	ZUU	04406
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/Medic	al	4a. Facility Name (If	Ra		homas	Les	scalleet	r Location of Deatl	Januar	-		12 10 A M
Examin	er	Frederic			,		Freder		n	40	. County of Dea Freder	
uneral	,	5. Social Security Nu			7. Age (In yrs. la	ast birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of B	rth ,		rthplace (State or Foreign country)
irector		215-42-84	71	XM 2□F	61	Yrs.	Months Days	Hours Min.	(Month, D March		1947 P	ennsylvania
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or 28	Director	10e. Street and Num					10f. Zip Code			10g. Ci	tizen of What C	ountry?
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Items	Funeral	11. Marital Status	and the second second	Armed Fo	edent Ever in U.S		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	<ol><li>Race - Am Black, Whi</li></ol>	
Department or neath and wenter righter in thems 23a or 28a-f show more any Injury or other traumatic event, the Marical Eventer must be notified at once.	ρ	1 ☐ Never Marrie 3 ☐ Widowed 4		If Yes, Giv Year or D	<sup>2□No</sup> 196 ve ates: 1986		1 □Yes 2XINo	Specify:			Specify:	White
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portar / Inju		21. Signature of Fun		·	Sta		2. Name and Addre				Funeral	
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		23a. Part 1. Enter the shock, or heart	e dise <b>ase</b> , or comp t failure. List only	plications that cone cause on e	auted the death ach line.	. Do not er	iter the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
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r: Afte	Certification:	1 ☑ Natural 2 ☐ Accident	5 Pending investigation	(Mont	h, Day, Year)	Injury	Work	√?  Yes 2 □ No  No  No  No  No  No  No  No  No  No	Loui Docoribo	now injur	iy oddanod	
irecto	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	of Injury - At hor	me, farm, st	reet, factory, office		28f. Location City or To			Rural Route Number,
eral D		29a. Certifier 1	N Certifying Ph	veician. To the	hest of my know	vledae dea	th occurred at the tir	mo date and place	and due to the	001100/0	and manner	as stated
To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical		2☐ Medical Exan	niner: On the b	asis of examinati ner stated.	ion and/or i	nvestigation, in my o	ppinion, death occu	rred at the time	, date and	d place, and du	e to the cause(s)
To th	ž	29b. Signature and ti	tle of certifier	. M.	D		29c. Licens	e number			ite signed (Mon	0
				y , m.		\ /==	MDD649	10		)	1-2+	2009
		30. Name and address PRATIMA			e of death (Item) W. 7th	Stre	et, Frede	rick, MD	21701			
Stat Registra		31. Date filed (Month		0 2009	egistrans Signati	ure	park	,			:	
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DHMH 17 Rev 1

Stephen Eugene Long

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 04407

		I- For State Registrar		Certi	ficate of	Death				Reg. No.			
Physicia		Decedent's Name (First, Middle, La	st)						2. Date of De Month	eath Day	Year		. Time of Death
Medical Examin	er	Stephen	Eugene		Long			N. L.	February	4, 2009	9		1237 hrs
	ı	4a. Facility Name (if not institution, g 2149 Canada Hill Road	ve street and number)		4.	b. City, Town Myersvill		on of Death		Fr	County of ederick	<	
Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last	birthday)	If Under 1		nder 24Hrs.	⊣			Foreign	place (State or
Director		219-54-5301	X <sub>M 2</sub> _F	59	Yrs.	Months	Days Ho	ours Min.	Jan :	31,19	50	Coun	mMaryland
		Usual Residence of Decedent				1							
any		10a. State 10b. County		1	own or Location								0d. Inside City Limits
faryland	5	Maryland Freder	ick	Myer	sville	}							1 Yes 2 X No
or Gire	Director	10e. Street and Number 2149 Canada Hill	Road			10f. Zip Cod 21	7 <b>7</b> 3			10g. Citiz	USA		y?
with the us 23a be noti	ig -	11. Marital Status	12. Was Decedent			Decedent o			ecify Yes or I	No-	14. Race White		n Indian, Black,
death or iter	Funeral	1 Never Married 2 Marrie	d . Armed Forces?		li fe	s, specify Ct	idan, Mexi	Jan, Fuerto	Rican, etc.)				
after	<u>\$</u>		d If Yes, Give Year 19 or Dates:			Yes 2 X					Specify:		
hours		15. Decedent's Education (Specify			<ol><li>6a. Decedent during mo</li></ol>	's Usual-Occ st of working				16b. Ki	nd of Bus	siness/Ind	dustry
5-0036 led within 72 hours after lygiene "natural"; officer han "natural"; the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	Posta	1 Del:	ivery			US	Gov	ernm	ent
withi withi giene rer th	Ē.		A\						(First, Middle	Maiden 9	Surname)		
21215-0036 ould be filed within 7 Mental Hygiens symmetred otter than it event, the Medica	BeC	17. Father's Name (First, Middle, Las William Jo		Long			Ma	rgare	t	Virg	inia	P	ryor
Sho and and in a sho		19a. Informant's Name/Relationship Gregory Long/Son	Type, Print )		19b. Mailing 7041 F	Address (S	creet and I	, Fred	tural Route N lerick	umber, Cit , MD	2170	3 State, 2	Zip Code)
Baltimore, M permit, Pages I and 2 Department of Health Important: If item 2 injury or other tran	1	20a. Method of Disposition		20b. Pla	ace of Disposi	tion (Name o	f cemetery		Date			-	own, State
Baltimore, permit, Pages I ar Department of He Important: If ite		1 XXBurial 2 Cremation 3		Resi	ematory or oth thaven	Mem G	ards	2/	10/200	9 Fr	eder	ick,	MD
Iltir nit. P antone sortar	1	4 Donation 5 Other Special Signature of Funeral Service-Lice			22. N	ame and Add	ress of Fa	cility Sta	auffer	Fune	ra1	Home	, PA
Dep Der	ľ	Roger WMill			162	21 Opo:	ssumt	own P	ike, F	reder	ick,	MD	
Physician		23 . 9ar 1. Enter the disease, or confailure. List only one cause on	plications that caused	the death. D	o not enter th	e mode of dy	ing, such a	as cardiac o	respiratory	arrest, sho	ck, or hea	art	Approximate Interval Between Onset and
/Medical xaminer	- 1		Atherosclerotic	Cardiova	scular Dise	ease Com	plicated	Ву Нуро	thermia			78	Death
Adminer		or condition resulting in death)	Due to (or as a cons	equence of):	14-14	1							
	-	Sequentially list conditions,	Due to (or as a cons	editence of/.		<del></del>							
	je 	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence or).									
tis q	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):						<del></del>			-
			J						<del></del>		_		
be experience	/Medical	UNPENDED	AMENDED										
	Š,	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregna		al death	3 Ec	topic pregna	ncv		. Date of Month	delivery Da	y Year
Box 68 e death certif	Physiciar	past 12 months?		t time of deat	_	ner (Specify)			_				•
BOy death death he att	isi	1 Yes 2 No 9 Unknow	9 Unknown										
P.O. s that the gned by t		Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying ca	ise given i	n Part I.					ne cause of death?
brds, P.O. Box 68:  w requires that the death certification is sheen signed by the attending should be detached for use as	Completed by												ibly 4 V Unknown
requirements	ete								24a. Wa au	topsy	p	nior to co	opsy findings available impletion of cause of
Recol The law cate has	Ĕ								pe 1 ✔ Ye	rformed?		leath?	2 No
tal Rec		25. Was case referred to medical				26.	lace of De	ath (Check	only one)				
Vital   Inysician: this certif	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 E	R/Outpatient	3 DOA	Other	4 Nursir	g Home 5	Reside	nce 6	Other:	Scene
Ing Ph	H 1	27. Manner of Death	28a. Date of Inj	ury 2	28b. Time of Ir	njury 28c.	Injury at V	Vork?	28d. Descrit Subject e				mental
ion tendir eath tor: A	Ę	1 Natural 5 Pending 2 ✓ Accident Investiga	FOUND: Found: Feb 4, 2009		FOUND: 1237 hrs	1	Yes 2	✓ No	temperati		0 1011 0	311411011	mental
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should the foundation of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director for the funeral director f	iţi	2 Accident Investigate 3 Suicide 6 Could no	28e Place of I	njury - At hon	ne, farm, stree	t, factory, off	ice building	g, etc.	28f. Location	n (Street ar	nd Numbe	er or Rura	al Route Number, City
Division of Vital Records, P.O. Box 6E 11 Inspital or Attending Physician: The law requires that the death cert 24 hours after death Funeral Director: After this certificate has been signed by the attendin tiely filled in by the funeral director, page 2 should be detached for use as	Certification:	4 Homicide determin	ed (Specify) Si	ngle Fami	ly				or Towr 2149 Cana	da Hill Ro	ad, Mye	rsville, l	MD
To the Hospital within 24 hours. To the Funeral completely filled		29a. Certifier 1 Certifying Phys	cian: To the best of n	ny knowledge	e, death occur	ed at the tim	e, date an	d place, and	due to the ca	ause(s) and	d manner	as state	d.
To the Ho within 24 F To the Fur completely	Medical	one) 2 Medical Examin	er:On the basis of exa and manner stated	mination and	i/or investigat				it trie time, da				
	Σ	29b. Signature and title of certifier					cense num	ber					th, Day, Year)
		Du my	) il jmo			0	.C.M.E.			Feb	ruary 6	, ∠009	
1511	t	30. Name and address of person wh				D 6:			D 04004				
7 =		Donna M. Vincenti, MD	Assistant Medi			Penn Str	eet, Balt	imore, M	21201				
Cto	ite	31. Date filed (Morlin, Day, Year)	32. Registra	ar's Signature	A la	akas							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 State Registrar Amended #4a,b,c & 26perMD FCHO ertificate of Death KS 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Year **Physician** 9 15 am am Derti 2 OL 2009 0 /Medical 4c. County of Death Frederick 4a. Facility Name (If not institution, give street and number) Kline/Hospice City, Town, or Location of Death Examiner Airy House Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F Director 051-26-5977 74 3. 1934 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Damascus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 10912 Kingstead Road 20872 United States Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other transment. Radiation Physicist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dante Lamperti Helen Russo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Camille L. Lamperti 10912 Kingstead Road Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) Gate of Heaven Cem. 9, 2009 Hawthorne, New York 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Furiera Service License 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netastatic rancilas cancer **Physician** 9/26/0 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending his made. burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has rail director, page 2 a autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospice Certification: To 1 ☐ Yes 2 ☐ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Vatural (Month, Day Year) Injury 1 Natural 2 Accident 5 | Pending 1 ☐ Yes 2 ☐ No investigation the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address

31. Date filed (Month,

Orkans St Balt, MD 2/23/

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 25 200 Warren Vance Murphy ANUAY /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) Town, or Location of Death Examiner umber CUMBELLAND
If Under 1 Year | If Under 24 Hrs. | 8, p Memoria Birthplace (State or Foreign Country) In vrs. last birthday 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Year Days Hours Months 7*8* 1 🖾 M 2 🗆 F Yrs 12/14/1930 214-30-9676 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Hampshire WW Springfield 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 HC-65 Box 1760 26763 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 □ No 1950 − If Yes, Give Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ō 1 ☐Yes 2 No Specify. ş 3 ☐ Widowed 4 Divorced White "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Operating Engineer Union uth and Mental Hw 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Wakefield Cora Murphy Virginia Rinker ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any Injury or other trausonce. Cheryl M. Feaster / Daughter 118 Dogwood Drive, Ridgeley, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Vet Cem @ Rocky Gap 01/29/2009 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, Sgnaure of Funeral Service 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on yach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 X No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy 2 **X** No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and matrice as stated.
2 Define Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar (Check only one)

29b. Signature and title of certifie

3

Saltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Print),

erson who completed cause of death (Item 23a) (Type

29c. License number

D0066101

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Della Elaine Mason /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner cestal Hos If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months 1071371938 1 □ M 2 🔀 F 70 220-32-9989 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo MD Director Worcester Snow Hill 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 402 Morris St. 21863 USA Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 is marked oth Chester Warrington Louise Powell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Morris St., Dick Mason / husband Snow Hill, MD 21863 other Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 1/31/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fineral Trvice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARCINOM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes □ No Month Year 5 Other (specify) ed by the a detached f 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 2 ANO 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation → Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

BAID

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

filed within 72 l

State Registrar

31. Date filed (Month, Day, Year) FEB 0 2 2009

3 Huyan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARE

COASTAL 32. Registrar's Signature Box 1733 Stris Buper mp 21802

			. 101	f Maryland	-				and Mo	ental Hy	giene	2000	01.1.	1 1
			State Registrar		Cei	tificate	of L	Death			Reg. No.	2009		1 1
	Physici		<ol> <li>Decedent's Name (First, Middle, Last)</li> <li>Taeko Betty</li> </ol>	McClin	tock					2. Date of De Month	Day	30.200	3. Time of De	
6	/Medic Examin		4a. Facility Name (If not institution, give street and nur	_		4b. City To	own, or l	Location of	of Death			County of De		
1	Funeral	and a	5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1		If Under	24 Hrs.	8. Date of Bir	rth /7	9. Bi	thplace (State or Fountry)	-oreian
()	Director		225-52-7498 1□M 2XIF	80	Yrs.	Months	Days	Hours	Min.	(Month, Da May 31	ay, Year) <b>,</b> 19	28	Japan	
$\sigma_{l}$	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City I	Limits
INI	a-f sh	ctor	Maryland Cecil			Ri	sind	g Sun					1 <b>X</b> Yes 2	□No
5	with the	Director	10e. Street and Number			10f. Zip C					10g. Citi:	zen of What C	ountry?	
7	ns 23a must	Funeral	100 McNamee Lane, Apt. N 11. Marital Status 12. Was Dece	edent Ever in U.S	S. 13. V	Was Decede		911 spanic Ori	gin? (Spec	cify Yes or No Rican, etc.)	D-	U.S. 14. Race - Am		
) 20 20 20 20 20 20 20 20 20 20 20 20 20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv	<b>X</b> X No		f Yes, specif 1 □ Yes 2[		n, Mexicar Specify:	ī, Puerto F	Rican, etc.)		Black, Whi		
77 5-0036	hours atural"	ed by	XIX Widowed 4 □ Divorced Year or Di	ates:	16a. Deced	fent's Usual	Occupa	tion			16b. Kir	nd of Business	White /Industry	
	thin 72 ie. an "na Medik	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1	-4or 5+)	(Give life. l	kind of work DO NOT use	retired)		t of workin	g	Bata	Shoe	Factory	
772	filed will Hygier ther the rut, the		Twelve Years  17. Father's Name (First, Middle, Last)			Lab	orer		er's Name	(First, Middle			aryland	
< $>$ $>$ Maryland 212	fental fental rked o	To Be	Toshimaru Su	ızuki					Sumi			iame un	known)	
Mary	2 shou and N Is ma		19a. Informant's Name/Relationship (Type. Print)					nd Numbe	er or Rural	Route Numb	er, City o	r Town, State,	Zip Code)	
~ 7	1 and 2 Health a tem 27 is		Frank McClintock (son)  20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name	e of	i		rt Depo		Mary 1	and 21904 Town State	<del>+</del>
A E	Pages nent of int: If Its iry or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State Ha	rford	matory or oth Memor dens	ial		02/03	3/09	Aber	deen.	Maryland	
7 AE/ Baltimore,	ermit. Pepartn nporta ny inju		21. Sign aure of Funeral Service Lioussee		22	. Name and	Pa++	s of Facilit	y n c C	on Fur	no ra l	Home,	A100	
,	a⊔ = e 0	Н	23a. Part1. Enter the disease, or complications that cancel, or heart failure. List only one cause on experience of the cause on experience of the cause of the c	aused the death	. Do not ent	Perry er the mode	vill of dving	e M	aryla cardiac or	nd 219	903 - 0	766	Approximate	
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	/Medical Examiner			ora a consequ	ence of):									
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause. (Disease or injury that initiated events	ni 6hih	mhile	DN	hm	7	disel	Ser				
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9	tificate g phys as the	ledical	a											
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0	the dea y the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ant at time of de own	eath 5□	Other (spec	cify)					WOTH	Day 16a	ar
S, P	w requires that the death certific been signed by the attending I should be detached for use as	by Ph	Part II. Other significant conditions contributing to de	eath but not resu	Iting in the ur	nderlying cau	use giver	n in Part I		23e. Did	tobacco u	se contribute t	o the cause of deat	th?
ord	requir	ted	(Minuy (12051)							1 🗆	Yes 2	]No 3∏F	robably 4 which	nown
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed	· · · · · · · · · · · · · · · · · · ·								psy ormed?	prior to death?	utopsy findings ava completion of caus	allable se of
/ital	iclan: The lav certificate has rector, page 2	Be C	25. Was case referred to medical examiner?					26. Place	of Death	1  Yes (Check only o	2 <b>N</b> o one)	1 □ Ye	2 1 No	
or V	Physic this co	ပ္	. — Hospital		ER/Outpatien			4 Nu		ne 5 Resi		Other (Spe	ecify)	
0.0	nding tth. r: After e fune	ation	1 ✓ Natural 5 ☐ Pending (Montage 2 ☐ Accident investigation	th, Day Year)	Injury	м	c. Injury Work 1   Y	?" 'es 2 🗌	_	ou. Describe	now injury	y occurred		
ivis	To the Hospital or Attending Physician: The ia within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of injury - At horng, etc. (Specify	me, farm, str	eet, factory,	office		28	8f. Location ( City or To	Street and wn, State	d Number or F	ural Route Number	r,
П	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Physician: To the	best of my knov	vledge, death	occurred at	t the time	e, date ar	nd place, a	nd due to the	cause(s)	and manner a	s stated.	
	To the Ho within 24 To the Fu	Medical		asis of examinati ner stated.	ion and/or in				ath occurre	ed at the time				
	T Wi		29b. Signature and title of certifier			290.	License	4 6 4	1/2		zau. Dat	e signed (Mon	S Day, Year)	
	1		30. Name and address of person who completed caus	e of death (Item	23a) (Type,	Print)	:M	n	21.	78		11	J	
	Sta	ite	31. Date filed (Month Day Year) 32. R	e of death (Item	ure	1100	AM	17		· '/ 0			-	
	Registr	ar	FED U & 2009 Fleren	v p.	granks									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2009 **Physician** 29 Karen Victoria Mackie January 11:25 a <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Cecil Elkton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 JF Months Days Hours Min. Yrs. 213-60-3892 55 Director MD November 2,1953 Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "hadical Exercitive rount be notified at once. 1 ☐ Yes 2 ☑ No Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 193 Rock Church Rd. 21921 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify. <u>Ş</u> Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier 7 is marked other th Butcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Dominic M. Saponaro Doris Cresswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) es 1 and 2 si of Health an David Michael Mackie/Husband 193 Rock Church Rd., Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R A Ferris & Co. Inc. 22. Name and Address of Facility West Chester, PA February 3,2009 Signature of Funeral Service Licensee Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** onav disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LOXIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. ed by the a 1 ☐ Yes 2 No 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 □ No 3 Probably 4 Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las 9.2 s autopsy page certificate 1 ☐ Yes 1 □Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner's Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (1

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 – For State Registrar	State of Maryla		artment of <i>rtificate of</i>			giene Reg. No. 200	9 04413
	Physici /Medic		Decedent's Name (First, Middle, Last     Mary	Jeanne	Mahev	1		2. Date of Dea Month 02	07 09	3. Time of Death 1250 M
	Examir		4a. Facility Name (If not institution, giv WMHS MEMORIAL C				or Location of Deat ERLAND	h	4c. County of D	
1	Funeral Director		5. Social Security Number 6. S 220-32-3870	ex	rs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da Jan 1	9. 1 5, 1937	Birthplace (State or Foreign Country) MD
padias	show	'n	Usual Residence of Decedent  10a. State 10b. County  MD Allec		City, Town or Lo	cation /ale				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
4	r 28a-f	Director	10e. Street and Number	,,		10f. Zip Code			10g. Citizen of What	^
4	s 23a c	eral [	11108 New York				21502		US	
in 30 course offer death with the Monday	ntal Hygiene.  tal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Expranter must be nutified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	- 1	was Decedent of fYes, specify Cul	Hispanic Origin? (Span, Mexican, Puer Specify:	specify res or No- to Rican, etc.)	Specify:	merican Indian, hite, etc. white
of craining	ne. han "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give		e during most of wor ed)	rking	16b. Kind of Busine	•
1019	I Hygie other ti	Be Co	17. Father's Name (First, Middle, Last,		Case	e Worker	7	me (First, Middle,	Social Se	ervices
od blue	and Menta is marked aumatic ev	To B	Henry Knierie		1				ers Knierie	
400	alth and 27 is n er traun		19a. Informant's Name/Relationship (  Don Mahew	Type. Print) husbaı			Y York Ave		er, City or Town, Stat <b>'ale</b>	e, Zip Code) MD 21502
Committee Dogger 1	ant; If item		20a. Method of Disposition 1 □ Burial 2 □ Ofemation 3 □	LHemovai from State   🦰		sition (Name of natory or other pla		Date 2/9/2009	20c. Location - City	
og times	Department of Health and Mental Important; If Item 27 is marked any Injury or other traumatic events.		4 □ Donation 5 □ Other (Specifical Signature of Fundral Service Liver	1		uneral Hon  Name and Addi Scar	rie, P.A. ress of Facility Delli Funeral H		Cresap	town MD
	hysician		23a. Part 1. Enter the disease, of com- shock, or/heart fullure. List only Immediate _ use (Final disease or ondition	dications that caused the debne cause on each line.	eath. Do not ent	er the mode of dy	/irginia Avenu	ie: Cumberla	and, MD 21502 rrest,	Approximate Interval Between Onset and Death
	/Medical xaminer		resulting (meath)	Due to (or as a cons	equence of):					
		ner	Sequentially list conditions,	b. METASTA  Due to (or as a cons		ING CAN	SCIN DININ			THREE MONTH.
bottooyo od otcoi	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):					
dooth cortif	e attending of for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★No 9 □ Unknown	23c. If yes, outcome of preg 1	etal death 3 [	Ectopic pregnar Other (specify)	ncy		23d. Date of Month	delivery Day Year
roca liros that the	igned by be detacl	by Phy	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause g	iven in Part I.			e to the cause of death?
W POCH IN	been s	ompleted						1 L N		Probably 4 Unknown autopsy findings available
The	ate has	Compl						autop	prior rmed? death	to completion of cause of
Dhyeinian.	certif	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	NED/Outrotion	* 3 T DOA O	hor:	ath (Check only o		
ing Dhy	After this	on: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o	f 28c. Inji	ury at ork?		dence 6 Other (S	респу)
l or Attending	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		home, farm, streetify)		⊒Yes 2 □ No	28f. Location (8 City or Tox	Street and Number or vn, State)	r Rural Route Number,
Hoenito	24 hours • Funeral etely filler	Medical C		nysician: To the best of my k niner: On the basis of exam and manner stated.						
To the	within To the compl	Me	29b. Signature and title of cortifier	m		29c. Licer	nse number Y/7 (ma	nrims)	29d. Date signed (M	onth, Day, Year) 9, 2009
F			30. Name and address of person who	1, M.D. 1068 1	VATIONA	Print)				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	bow de A				

DHMH 17 Rev 1/2001

	Please	Type or Print in Black		•	_
	For State		epartment of Health and	Mental Hygien	1e 2009 06614
	Registrar  1. Decedent's Name (First, Middle, La		Certificate of Death	2. Date of Death	3. Time of Death
Physician /Medical	GEORGE EI	OWARD MCPHEE		FEBRUARY	<sup>Day</sup> 5 2009 9:11 P <sup>M</sup>
Examiner	4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Deat  LA PLATA	th 4	c. County of Death CHARLES
Funeral	5. Social Security Number 6.	Sex 7. Age (In yrs. last birth		8. Date of Birth     (Month, Day Yea	
Director	473-34-5919 Usual Residence of Decedent	1 <sup>M</sup> M 2□ F 90 Y	s.	8. Date of Birth (Month, Day, Yea MAR • 26 , 1	918 NORTH DAKOTA
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene.  I marked other than "naturel" or items 23a or 28a-f show umatic event, the "Medical Event in a roughle of the Ton Re Commission in Finneral Director.	10a. State 10b. County	10c. City, Town			10d. Inside City Limits 1
vith the Mary t or 28a-f st be notified	MD CHARLE  10e. Street and Number	ES LA PI	10f. Zip Code	10a (	Citizen of What Country?
with t	215 STARKEY CO	ידקווו	20646	10g. C	U. S. A.
after death wi	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (\$	Specify Yes or No-	14. Race - American Indian,
after or ite	1 ☐ Never Married 2 ☐ Married	Armed Forces?  MXYes 2 □ No If Yes, Give	If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2 ☒ No Specify:	to Rican, etc.)	Black, White, etc.
urel", o	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		4.01	Specify: WHITE
ed within 72 hou ygiene.	15. Decedent's E (Specify only highest gr	ade completed) (	Decedent's Usual Occupation Give kind of work done during most of wo life. DO NOT use retired)	rking	Kind of Business/Industry
y withi	Elementary/Secondary (0-12)	College (1-4or 5+)	ME BUILDER		ME CONSTRUCTION
VIGILIA C. 1.4  uld be filed with Mental Hygiene arked other that atic event, free	17. Father's Name (First, Middle, Las	•		me (First, Middle, Maide	•
y la	GEORGE EDWARD				ISE GEBHARDT
VICE Shand 7 Is m	19a. Informant's Name/Relationship	` ' ' .	Mailing Address (Street and Number or R		
tem 27	MICHAEL H. MCI  20a. Method of Disposition		00 OLD STAGECOA Disposition (Name of crematory or other place) FEB		A PLATA, MD 20646  Location - City or Town, State
Pages nent of ant: if its	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Li Hemovai irom State			EXANDRIA, VA.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 23a or 28a-f show amportent: if item 27 is marked other than "hatter!", or items 23a or 28a-f show amplified at once.  To Re Committee by Finneral Director	21. Signature of Funeral Service Lice	+ ( / _	22. Name and Address of Facility R	AYMOND FU	NL.SERVICE,P.A.
20522	How 1180	M00641	5635 WASHINGTO	N AVE., L	A PLATA,MD20646
	shock, or heart failure. List only	nplications that caused the death. Do no one cause on each line.	it enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)	a. On CO ODS  Due to (or as a consequence of	notive pulmona	y diseas	se
Examiner	Consumation like the new distance	athernsclere		cular dis	ease
tec sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	):		
	resulting in death) Last	c Due to (or as a consequence of	):		
ificate be physicial as the bu		d		·	
certific certific ding p	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery
death cer e attendir d for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
at the lby the stache	9 Unknown	9 🗆 Unknown			
Physicien: The law requires that the death certificate rithis certificate has been signed by the attending physral director, page 2 should be detached for use as the transfer of the physician model.	> Fait II. Other significant conditions	contributing to death but not resulting in	he underlying cause given in Part I.	1/	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
law rec				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The cate h				performed? 1 ☐ Yes 2 🔼	death? No 1 Yes 2 No
VITAL sicien: T certifical rector, pa	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only one)	
Phys	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Ti	Jatient 3 DOA 4 Divursing	Home 5 ☐ Residence 28d. Describe how in	
Attending or death.  rector: Afte by the fune	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Inj on	me of 28c. Injury at Work?  M 1 □ Yes 2 □ No		,,
or Atter de after de Directo	27. Manner of Death    Natural   5   Pending investigation   3   Suicide   4   Homicide   Homicide   Homicide   Homicide   Homicide   Pending investigation   1   Natural   5   Pending investigation   2   Natural   5   Pending investigation   3   Suicide   6   Could not determine   4   Homicide	n, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
	29a. Certifier Certifying F	Physician: To the best of my knowledge, aminer: On the basis of examination and and manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occ		e(s) and manner as stated. and place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier	7	29c. License number	29d. I	Date signed (Month, Day, Year)
	<b>&gt;</b>   <b>                 </b>		D22574		29/09
		completed cause of death (Item 23a) (			
State	ROBERT PACÉ, 31. Date filed (Month, Day, Year)		LINE CENTER #30:	2 WALDORF	MD 20602
Registra		1/2 //2	parked		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?  $\bigcap \bigcap G$ Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 2009 FEB. 11:20A IDA WYNNE NEAL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOMEWOOD AT CRUMLAND FARMS FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 M F Director JUNE 30 1914 VA 214-16-7063 94 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MONTGOMERY POOLESVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20611 WHITES FERRY ROAD 20837 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: WHITE þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ EDWARD J. WYNNE IDA LAKE NEEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20837 19a. Informant's Name/Relationship (Type. Print) 20611 WHITES FERRY RD., POOLESVILLE, MD MIKE BUPP / GRANDSON-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐Removal from State MONOCACY CEMETERY 2/9/09 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a/consequence of Examiner burial-transi Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Upknown 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Records,

Division or Vital

My sician as

NOW

ORIGINAL

Darks

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32. Redistrar's Signature

21701

REDERICK MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

asper Cline, mD

rith, Day, Year) FEB 0 9

State of Maryland / Department of Health and Mental Hygien [] [] 9 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day January 24, 2009 **Physician** Travis Edward Nickel 02:50 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany County Nursing and Rehab Center Allegany Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **1** M 2 □ F 220-08-5430 23 Yrs. September 09, 1985 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23e or 28e-f show the Medical Examinat must be notified at 1 Yes 2 No Maryland Allegany LaVale Directo 10e. Street and Number 4 Oaklawn Avenue 10f. Zip Code 10g. Citizen of What Country? 21502-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced 15. Decedent's Education Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled disabled of Health and Mental Hygie itam 27 is marked othar rother traumatic avant. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) h and Mental I Karl Nickel Linda Beeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Beeman mother 4 Oaklawn Avenue 21502-LaVale Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State ō = 5 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department o Importent: If any Injury or once. January 26, 2009 Cumberland Crematory Cumberland Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility olu > Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PRESSURZ HYDROCEPHALUS Pnysician NORMAL YRS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine and I-transit to the Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 🗆 No 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the **Director:** 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1.and mberland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Memoria Hospital Medical Buildy

Registrar DHMH 17 Rev 1/2001

State

MLS

Rohus

31. Date filed (Mog

Barrera 32. Registrar's Signature

			For State	Plea				and / D	Оера	rtme	nt of H	Ensure lealth ar		•		_	e.		
	Physicia	าก	State Registrar  1. Decedent's Name	e (First, Middle		71			Cert			Death		2. Date of D	D	20 (	9	3. fine	of Death
1	/Medic Examin	al	4a. Facility Name (I	If not institution	, give stree					4b. City		Location of I	Death	01	2.2	2 0 9 c. County of D ALLEGA	Death	103	0 📉
	Funeral Director		5. Social Security N 215-20-51	lumber	6. Sex		7. Age <i>(In y</i>		thday) Yrs.		r 1 Year	If Under 24	Hrs. Min.	8. Date of Bi	irth 1916	9.	Birthpla	virg:	or Foreign
	Aaryland f show	or	Usual Residence of 10a. State MD	10b. County	Legany	7	10c.	City, Town		ation	and						10		City Limits
	h with the M 23a or 28a-	al Director	10e. Street and Nu				l !				p Code	02			10g. C	itizen of Wha		ry?	
ივი	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evanciant rougher houlded.	by Funeral	11. Marital Status 1 ☐ Never Marr 3 🏻 Widowed	_	ied 1	Vas Deced rmed For ☐Yes Yes, Giv 'ear or Da	e	ı U.S.			edent of Fecify Cub:	ispanic Originan, Mexican, F	n? (Spec Puerto R	cify Yes or N lican, etc.)	0-	14. Race - Black, V	Vhite, et		
1212-0036	thin	Completed	(Spec	15. Decedent cify only highes andary (0-12)	t grade con	n <i>npleted)</i> College (1-	4or 5+)	16a.	(Give k life. D	ind of w	ual Occup ork done use retired tres	during most o d)	of working	g	16b.	Kind of Busin	ess/Indu		
Jana z	uld be filed wi Mental Hygien Irked other th	To Be Co	17. Father's Name John	(First, Middle,	Last) Fra	nk		Chamb				18. Mother's Ber		(First, Middle	e, <i>Maid</i> e Mae	n Surname)		Mallo	)W
e, mary	d 2 sho th and I 7 Is ma trauma		19a. Informant's N Patricia	Lease	, , , , ,	,		1	016	Bro	wn A	and Number	Cum	ber1a	nd,	MD 21	502		
baitimore	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 200ce.		20a. Method of Dis 1 ⊠ Burial 2 4 □ Donation	☐ Cremation 5 ☐ Other (S	pecify)	val from S		b. Place of cemeter unset	t Me	mor	lal P	ark 0		6/2009	Cu		ind,	MD	D. A
מ	perm Depa Impo any l		21. Signature of Fo	the disease, or	Lacomplication	ms that ca	aused the d	eath. Do r	40	4 De	catu	r Stre	et,	Cumbe	rlar		21.	502 Approxima	ate
الم	Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	on	only one ca		or as a cons	l'ov	of):	or	4hc	}					-	Interval Bronset and	etween d Death
68/6U,	eath certificate be executed attending physician and for use as the burial-transit	lical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	S	b c d	,	or as a cons	· 											
O. Box 6	the death certificate by the attending phys ached for use as the l	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 0 9 □ Unknown	months? ☑Ño		Live b	come of pre irth 2   F lant at time own	etal death		Ectopic Other (	pregnanc specify) _	y				23d. Date o Month		y Day	Year
cords, r	w requires that the d been signed by the should be detached	ρχ	Part II. Other signi	ficant condition	ons contribu	iting to de	ath but not	resulting ir	n the un	derlying	cause giv	en in Part I.				use contribu			f death? Unknown
Ū T	The larate has	Completed												24a. Wa auto peri 1 □Yes	opsy formed?	prio dea	r to con th?	sy finding pletion of	s available f cause of
on or vital	his I dii	ition: To Be	25. Was case referexaminer?  1 Yes 2  27. Manner of Dea  1 Natural 2 Accident	Mo	g	8a. Date o	npatient 2 of Injury h, Day, Year	28b. 7	utpatient Time of Injury	t 3 □ [	28c. Inju Wor	er: 4 🗆 Nurs	sing Hom		sidence	6 ☐ Other (	(Specify	)	
DIVISION	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	ined	buildir	of Injury - Ang, etc. (Sp	ecify)						City or To	own, Sta				ımber,
	the Hosp thin 24 hou the Funer mpletely fil	Medical	29a. Certifier (Check only one)	1 Certifyir 2 Medical	Examiner:	n: To the On the ba and mann	asis of exaln	knowledge nination an	e, death nd/or inv	estigation	on, in my	opinion, death	l place, a n occurre	nd due to the d at the time	e, date a	nd place, and	d due to	the cause	
)	£ № 6 8		29b. Signature and	1/1	ruy	Todacus	a of dooth /	Itom 22a	(Type 5		DS	se number			JA	pate signed (A	22	, 2.	wg
	nls Sta	te	31. Date filed (Mar	omen	dity	at	gove	mature	XY S	0792	Ta	RIVE	CV.	nben	المنآ	DI M	08	3120	13
	Registr		JA	N 23°2	אר אחר	Ruy	egistrar's Si	1.	arth										

Months

Dalton

7. Age (In yrs. last birthday)

82

Certificate of Death

Parker

Days

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Cumberland

Hours

Min.

Date

Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 28a-f show Exemine must be notified at Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code ō 434 Pine Avenue 23a 21502 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done' during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If Item 27 Is marked other any injury or other traumatic event, It 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Henry Powell ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Meekins / Daughter 118 Independence Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 01/26/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Lice lday 404 Decatur Street, Cumberland, MD 20 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the darking Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ 1100 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 1 Natural 5 Pending

investigation

determined

6 ☐ Could not be

2 Accident

4 Homicide

29b. Signature and title of certifier

3 ☐ Suicide

31. Date filed (Mont.

29a, Certifier

1. Decedent's Name (First, Middle, Last)

Dorothy

5. Social Security Number

234-40-3129

WMHS-Memorial Campus

4a. Facility Name (If not institution, give street and number)

1 □ M 2 😾 F

**Physician** 

/Medical

Examiner

**Funeral** 

Director

3. Time of Death

8:22 A

9. Birthplace (State or Foreign Country) West Virginia

10d. Inside City Limits

1 ☐ Yes 2 No

2. Date of Death

January

8. Date of Birth (Month, Day, Year) 08/13/1926

21,

2009

Allegany

4c. County of Death

10g. Citizen of What Country?

Specify

16b. Kind of Business/Industry

USA

14. Race - American Indian, Black, White, etc.

Brumback

20c. Location - City or Town, State

Cumberland, MD

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Year

Month

23e. Did tobacco use contribute to the cause of death?

24a Was an 1 ∐ Yes

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D36766

2 No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown

1 ☐ Yes

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

January 22, 2009

21502

Black

21502

Approximate Interval Between Onset and Death

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramaditya Poonai, M.D., 924 Seton Drive, Cumberland, MD

s after death

within 24 hours a To the Funeral D

2

nes

filled in by the

	U	r.ţ	14	1	J
T	3 Tir	ne c	f De	ath	

Physicia /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evanture; must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	- negistrar				00/1///	0010 01 E	00		Re	g. No.		
n	1. Decedent's Name		PALMER						Date of Death Month	Day	Ye ar 2009	3. Time of Death
r	Α ,	47	ve street and number)	.1 1	4b.	City, Town, or	Location of	Death	Ú	4c. County o		
ě	Mentgon  5. Social Security N		- 11		45 - 1 - 1 - 1 F I	Under 1 Year	If Under 2	4 Dro To	Data of Diata	Montgo		
	212-20-1		Sex 1 M 2 □ F	(In yrs. last birt		nths Days	Hours	Min.	Date of Birth (Month, Day,	Year)	Country	
	Usual Residence of			02				1	'eb. 1	1927	Mai	ryland
	10a. State	10b. County		10c. City, Town	or Location	n					10d.	Inside City Limits
CTO	Md.	How	ard	W	oodb <b>i</b> :	ne						1 □Yes 2 X No
Dire	10e. Street and Nu				10	of. Zip Code	01707		10	g. Citizen of Wh	,	
ā	2725 Dai	Lsy Road					21797			United	ı stai	ces
Ę.	11. Marital Status	:	12. Was Decedent E Armed Forces?		13. Was I	Decedent of His , specify Cubar	spanic Orig n, Mexican,	in? (Specif Puerto Ric	y Yes or No- can, etc.)		<ul> <li>American</li> <li>White, etc.</li> </ul>	
Completed by Funeral Director	3 Widowed	ied 2 Married 4 Divorced	1 Mayes 2 □ N If Yes, Give Year or Dates:	WWII	1 🗆 Y	es 2 <b>X</b> No	Specify:			Specify:	Whit	te
ere	(Spec	15. Decedent's E cify only highest gr	ducation ade co <i>mpleted)</i>	16a.	(Give kind	Usual Occupa of work done di	uring most	of working	11	6b. Kind of Bus	iness/Indus	try
Ĕ	Elementary/Seco	ondary (0-12)	College (1-4or 5-	+)		<i>'OT use retired)</i> nager				<b>സ</b> രി ഹി	aono (	Company
	17. Father's Name	(First, Middle, Last			Mai		18. Mother	's Name (F	First, Middle, Ma	aiden Surname		company
lo Be	Jacob	G. Pal	mer					tha		Hall		
	19a. Informant's N			19b.	Mailing Ad	dress (Street a	nd Number	or Rural F	Route Number,	City or Town, S	tate, Zip Co	ode)
			/ Daughter				Road,			Maryland		797
	20a. Method of Dis		Removal from State		y, cremator	y or other place	, ,	Date		Dc. Location - C	ity or Town	, State
	4 Donation	5 ☐ Other (Speci	fy)	Oak Gr		emetery	1	2/10/	/09	Glenwo	od,	Md.
	21. Signature of Fu	uneral Service Lice	nsee	la o.	22. Nai	me and Addres uriel H	s of Facility L. Bar	ber E	uneral	Home		
_	23a Part 1 Enter t	he disease or com	plications that caused	the death Don	P	. O. B	ox 50	38, I	aytons	<u>ville, I</u>		0882
	shock, or hea	art failure. List only	one cause on each lin	e.			, such as c	ardiac or n	espiratory arres	SI,	In	pproximate terval Between nset and Death
	disease or condition resulting in death)		a	Acul	<u> </u>	17						
			Due to (or as a	consequence o	(1): - <b>L</b>							
je	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	nditions, nmediate	b Due to (or as a	a consequence of	of):							
Ē	Cause (Disease or that initiated events	rinjury	c	CO	09							
Ĭ	resulting in death)	Last	Due to (or as a	consequence o	of):					-		
lca I		•	_d									
n/Medical Examiner	IF FEMALE:										1	
$\boldsymbol{\sigma}$	23b. Was deceden in the past 12		23c. If yes, outcome of	2 🗀 Fetal death						23d. Date Mont	of delivery th Da	y Year
Completed by Physici	1 ☐ Yes 2 [ 9 ☐ Unknown	□No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5∐Oth	er (specify)				Mon		y rour
7	Part II. Other signit	ficant conditions	contributing to death bu	t not resulting in	the underly	yi <b>n</b> g cause give	n in Part I.		23e. Did toba	acco use contrib	oute to the o	cause of death?
Q D	Coa	quepathy							1 ☐ Yes	2 □ No 3	B□ Probabl	ly 4 Unknown
Siet		) / /							24a. Was an	24b. W	ere autopsy	/ findings available
Ē			11.00						autopsy	ed? de	ior to compleath?	letion of cause of
De C	25. Was case refer	red to medical					26. Place	of Death (C	1 □Yes 2 Check only one		∐Yes 2	No
	examiner? 1 ☐ Yes 2 🔀		Hospital:		tpatient 3	□ DOA Othe	r: 4 🗆 Nur	sing Home	5 Residen	ice 6 □Other	(Specity)	
 .:	27. Manner of Deat	5 Pending	28a. Date of Injur (Month, Day	y 28b. T (Year) Ir	Time of njury	28c. Injury Work	at ?	280	d. Describe how	injury occurred	t	
cat	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b			N		es 2□N					
ertit	4 Homicide	determined		ry - At nome, far . <i>(Specify)</i>	rrn, street, f	actory, office		28f	Location (Stre City or Town,	eet and Number State)	or Rural R	oute Number,
<u>ت</u>	29a. Certifier	1 <b>X</b> Certifying P	hysician; To the best of	of my knowledge	e, death occ	curred at the tim	e. date and	d place and	d due to the ca	use(s) and man	ner as state	ed
Medical Certification: 10	(Check only one)	2 Medical Exa	miner: On the basis of and manner sta	examination an	d/or investi	gation, in my op	pinion, deat	h occurred	at the time, da	te and place, ar	nd due to the	e cause(s)
Σ	29b. Signature and	title of certifier	0.0			29c. License	number		29	d. Date signed	(Month, Day	y, Year)
	<b>1</b>	Sichhum	yinn			y51	1446			February	5	2009
	0.11	ress of person who	completed cause of de	eath (Item 23a) (	(Type, Print)		ip I	Dr. , O		M9 8	10832	)
е	31. Date filed (Mon	th, Day, Year)		r's Signature	1	41	V. /		J			
r		red 1192	1004 Dense	M B.	Dan	100						

Stat

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G888 2/20/09 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Month 10:30 PM REINALDO FEBRUARY PINTO 009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 218-90-8630 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Months Director 68 25, 1940 Feb. Portugal Usual Residence of Decedent death with the Maryland 10b. County 10a State 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits Injury or other traumetic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Carrol1 Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3525 Gilboa Drive Funeral 21771 Portugal 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of the filed within and Mental Hygiene. Thent of Health and Mental Hygiene. Sont: If Item 27 Is merked other than "naturel", or itee 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Pinto ဂ္ Vitoria Lourenco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana Dasilva - Daughter 3525 Gilboa Drive, Mount Airy, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It eny Injury or concern 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2/12/09 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 26401 Ridge Road. Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Qualto (or sels consequence on To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for Day Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 2 🕽 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient Certification: To 2 ER/Outpatient 3 DOA To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours a To the Funeral I

Medical

29a. Certifier

29b. Signature and title of cer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ifier

and manner stated.

Ghulam Abbas, 400 West 7th Street, Frederick, Maryland M.D. 32. Registrar's Signature 31. Date filed (Month 9

State Registrar 15 Certi ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medi at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D62471

29d. Date signed (Month, Pay, Year)

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04421 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 4, 200<sup>°</sup>g<sup>ar</sup> Joanne Gilman Penn 12:30A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 012-26-9958 73 1935 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland | Howard <u>Columbia</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6328 Sandchain Road 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 ☐Yes 2 No Specify: White 3 Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Gilman Marguerite Charbonneau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Sandchain

6328 Sanchain Road, Columbia, Maryland 210 19a. Informant's Name/Relationship (Type. Print) Jerry E. Penn - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Mount Olivet Cemetery 2/9/2009 Frederick, Maryland 21. Sign ture of Fl neral Service Dicenses Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final unt disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

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spital or Attending Physician: Ti hours after death. Ineral Director; After this certificate y filled in by the funeral director, pa

within 24 hours a

To the Funeral C

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law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

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**Examiner** 

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7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death v

and Mental Hygiene is marked other than

t of Health a: If item 27 is Department of Health Important: If item 27 any Injury or other trong once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

29b. Signature and little of certifier

3 ☐ Suicide

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be

determined

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

4 Homicide 29a. Certifier (Check only one)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) 19ma Date filed (Mont

32 Registrar's Signature

State Registrar

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			State Registrar	- 4\		Cei	rtifica	te of E	Jeatn 				.2009	3. Time of Dea		
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F.	Examin	er	Transitions Heal					cesvi		or Death		'	Carroll			
	Funeral		5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under		8. Date of Bir	th .	9 Rinth	place (State or For	reign	
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	e Ma Ba-f s	cto	Maryland Carroll Sykesville										1 Tyes 2	1140		
	or 2 be no	Director	10g. Street and Number 10f. Zip Code 21784									10g. C	Citizen of What Country?			
	s 23a	ral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								aif. Vac as No		USA 14. Race - Amer	oon Indian		
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last LeRoy Deame)								<i>(First, Middle</i> . Forbes	le, Maiden Surname)				
3	nould I Mer narke natic	ဥ				101 14 11		(2)								
<u>¶</u> al	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Ш	19a. Informant's Name/Relationship ( Grant Pensinger		and)		_	•					City or Town, State, Zip Code) ster, MD 21157			
	1 an Heat em 2		20a. Method of Disposition	(Hubb	20b. F	Place of Dispo	sition (Na	me of	-		Date		Location - City or 1			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ion (	ath. r: After e funera	ation:	1 Natural 5 Pending	Ba. Date of Inju (Month, Da	iry 2 ly, Year) 2					28d. Describe	how inju	ry occurred			
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To the withing To the complex	Me	29b. Signature and title of certifier		-	_	29c. L	icense	number	70.00	29d. Da	ate signed (A	Month, D	Day, Year)	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				1 palee	05	) ~	1	)   ,	1)	005	(891	0	1-0	6	-2009	
Citato	N	512		30. Name and address of person who comple	ted cause of d	eath (Item 2	(3a) (Type, F	Print)	1	ole !!	lle	4	Photo	Po	12/M7	
TITLE OF THE PARTY ALL PROPERTY AND A VANCOUS TO					32. Registra	ar's Signatur	Some	اري	-	3 1		<del>\</del> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Jun	41	40,040	

			1 - For State of Maryland / Depar Registrar Certif	tment of Health and M ificate of Death	lental Hygi	ene g. No 2009	04424
ı	Physici /Medio		Decedent's Name (First, Middle, Last)     Delores C. Spitznas		2. Date of Death Month Januar	y 25, 2009 Year	3. Time of Death 02:25 PM M
*	Examir		4a. Facility Name (If not institution, give street and number)  220 Braddock Road	b. City, Town, or Location of Death Frostburg		4c. County of Death	
Ī	Funeral Director		214-28-6569 1 M 2 F 79 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, October 0	Year) 9. Birth	place (State or Foreign ntry) yland
	sryland show	١	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	tion			10d. Inside City Limits
	r 28a-f	Director	Maryland Allegany Frostburg  10e. Street and Number 220 Products Pood	10f. Zip Code	100	g. Citizen of What Cou	1 Yes 2 No
	23a or		220 Braddock Road	21532-		J.S.A.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
980	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "naturel", or items 23a or 28a-f show atte event, it is Modical Evarillar must be notified at	by Funeral	1  Never Married 20 Married 1	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	etc.
Maryland 21215-0036	d within 72 hagiene, r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Secretar	nt's Usual Occupation Id of work done during most of workir NOT use retired)	ng	State university	
and	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		
aryla	es 1 and 2 should be of Health end Menta I Item 27 is marked r other traumatic ev	၉	Lester Chapman  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing A	Bessie Will Address (Street and Number or Rura		City or Town State Zi	2 Codo)
	and 2 sealth en n 27 is		T C C 't		t <b>burg</b>	Maryland	21532-
w	Pages 1 nent of Hi int: If Iten iry or oth		20a. Method of Disposition  1 ★Burial 2 □ Cremation 3 □ Removal from State			c. Location - City or To	
altin	permit. Pages Department of Important: If It any Injury or once.		4 □ Donation 5 □ Other (Specify) Maryland State Vol. Signature of Funeral Service Licensee 22. N	eteran's Cemetery Januar	y 29, 2009 F	lintstone M	aryland
ñ	any per			Ourst Funeral Home, 57 F	rost Ave., F	rostburg, MD	21532
	Physician /Medical Examiner		23a. Papt. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	. 2		t,	Approximate Interval Between Onset and Death
8/60,	ficete be executed physicien end s the burlai-transit	I Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
289	fificete g physi as the t	edical	d				
ğ į	w requires that the death certifing is been signed by the attending is should be detached for use as	Physician/Me		ctopic pregnancy ther (specify)		23d. Date of delive Month	ery Day Year
ords, P	requires that the	þ	Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions.	cco use contribute to the	ne cause of death?		
Hec	t: The law re icate has be ; page 2 sh	Completed	Hyperkinston		24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of 2 No
<u> </u>	Pnysicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2  Ho Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death			
ם ח	Ing Ph	on: T	27. Manner of Death 1 CNatural 5 □ Pending (Month, Day, Year) 1 Pending (Month, Day, Year) 1 Pending (Month, Day, Year)		8d. Describe how	e 6 ☐ Other (Specifinjury occurred	y)
DIVISION	to the fooghtal of Attending Physicien: The law within 24 hours after that.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification: To		M 1 ☐ Yes 2 ☐ No factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,
	the Hospit hin 24 hours the Funera	Medical (	29a. Certiffer (Check only one)  Certifying Physician: To the best of my knowledge, death or physician in the desired of my knowledge in the desired of my knowledge in the	occurred at the time, date and place, a tigation, in my opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
	with Con	2	29b. Signature and the of certifier home hand must	29c. License number  25 3 5 7 35	29d	Date signed (Month,	Day, Year)
-	nows		30. Name and address of person who completed cause of death (fem 23a) (Type-Prin	ZSekan D.	- Pin	herken	1 ma
	Sta Registra		31. Date filed (Month, Pay, Year) 2009 3. Registrar's Signature for Signature	V	CVIP	100 /5108	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04425 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month January 24, 2009 Marjorie Louise Sheirer 10:05 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Egle Nursing and Rehab Center Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Min 1 □ M 2 1 F Months Yrs Director 215-16-4733 86 March 25, 1921 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unty or other than unty or other traumatic event, I'm Medical Expension must be notified at uny or other traumatic event, I'm Medical Expension 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Allegany Frostburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 105 George Street Funeral U.S.A 21532- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Lewis Sluss Margaret Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type. Print) Lisa Sheirer 6621 Mountaindale Road **Thurmont** Maryland 21788-20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State January 26, 2009 4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** Cumberland Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 210 1 🗆 Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier MD 00055 325 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MRS 925 BISHOP WALSH RD cumberland MD 21502 WONSOCK SHIN 31. Date filed (Menth 6 2. Registrar's Signature State Registrar

P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04426 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Herbert Beverly Staples 12:04 PM 29, January 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 6. Sex 1 M 2 F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 22, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 85 Director 579-22-3254 1923 Maine Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2 No Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 885 Ocean Parkway Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Dog; il | 1∠∠1/2>
■ Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify 3 ☐ Widowed 4 ☐ Xoivorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Realty Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert O. Staples Fosta Mae Cousins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other tra Susan Simmons, Daughter 8504 Caswell Road, New Carrollton, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 1/31/09 Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 Williams Street, Berlin, Maryland 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Preumo nia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 □ Yes 2 No Staples, Hybert & Division of Vital 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and didress of person who completed cause of death (Item 23a) (Type, Print) BAID H (AH 9733 32. Registrar's Signature coulth way drive ee shah 31. Date filed (Month, Day, Year) FEB 0 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

579-22-3254

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle Last) Year Day **Physician** 2009 100 8:33 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wico mico at Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Hours Months Davs 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ariment of Health and Mental Hygiene.
ortant: If Item 27 is marked other than "natural"; or items 23a or 28a-f show injury or other traumatic event, I'm Me Jeal Examinat must be notified at Yes 2 No Director 10g. Citizen of What Country? Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black White, etc. 1 □Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Drummond ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau Coston (daughter 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 8: Name and Address of The Bennie Smith F/H md -21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ESOPHAGRAL Physician CINDM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 ☐ Yes 2 ☐ ₩fo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an After this certificate has funeral director, page 2sautopsy performe 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence Gother (Specify) HOSPICIZ 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O BOX 1733 SALISBULLY MED BA3 Huggen WAMS DASTAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 0 2 2009

Jacks

			State of Maryland / Department of Hea  State Registrar  State Certificate of De		ygiene 0 0 9	04428
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of ( Month	Death Day Year	3. Time of Death
	/Medic	al	Joseph Wrightson Simmers	Janua		0535 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If t	de Grace Under 24 Hrs. 8. Date of E	Harfo Birth 9. Birth	rd place (State or Foreign ptry)
	Director		213-12-0900 *XXM 2 F 89 Yrs. Months Days H			ryland
	pu 🛦		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			0d. Inside City Limits
*	darylar f ehow	ō		4:110		Y Yes 2 No
	death with the Mary ms 23a or 28a-f ehe rmust be notified	Directo	Maryland Cecil Perryv  10e. Street and Number 10f. Zip Code	71116	10g. Citizen of What Cour	7.7.
M	th with	al D	624 Charles Street 2190	13	ΙΙ ς Δ	
7	ems ermi	Funeral		inic Origin? (Specify Yes or I Mexican, Puerto Rican, etc.)	No- 14. Race - Americ Black, White,	
36	urs after death with the Maryla at', or frems 23a or 28e-f ehov Evanther must be notified at	<b>by</b> Ft	1 Never Married XX Married No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	pecify:	Specify	hite
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	hin 73	Completed	(Specify only highest grade completed) (Give kind of work done durin life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	ig most of worki⊓g	V.A. Medica	1 Čenter
J 6	illed with Hygiene other the	Соп	Twelve Years Carpenter		Perry Point	, Maryland
2	be fill hall H	Be	17. Father's Name (First, Middle, Last) Paul Simmers	. Mother's Name (First, Midd		
ME	should be nd Menta marked	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and I		Charsha	Code)
5 ₹	nd 2 salth ar 27 io		Myrna M. Simmers (wife) 624 Charles Str			
SIMMER	ges 1 and 2 should be flied withing to 1 and 2 should be flied withing to Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, I and		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or To	own, State
	Pag ment tent: I		4 Donation 5 Other (Specify) Hopewell Cemetery	02/05/09	Port Deposit	, Maryland
) <u>F</u>	permit Depart Impor		21. Signature of Funeral Service Licenses  1. Signature of Funeral Service Licenses of Lee A. Patte Perryville,	erson & Son Fi	uneral Home,	P.A.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause of each line.	uch as cardiac or respiratory	arrest,	Approximate Interval Between
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	ocuted nd transit	Examiner	that initiated events	docurrent	w.	2 weeks
760	te be executed ysicien and be burial-transit		resulting in death) Last byg to (or as a consequence of):	Ture / Ban	- dialout	9 4000
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20 900 Nital Records, P.O. Box 68	The law requires that the death certification has been signed by the ettending phage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	,	23d. Date of delive	arv
ă	te death the ette	sicia	in the past 12 months?  1	desir Martin Control of the Control	Month	Day Year
C	thet the death	Phys	9 U Onknown			
<i>y</i>	signed d be de	by	Part II. Other significant conditions contributing to death burger suiting in the underlying cause given in	under	d tobacco use contribute to t Yes 2 □ No 3 □ Prot	
	v requires been sign should be	etec	Lavete War Day Day	N -		
S &	he lav e has	Jup	Son a valence occurre of		topsy prior to co rformed2 death?	psy findings available mpletion of cause of
O E	ding Physician: The la h. After this certificete has funeral director, page 2	BeC	25. Was case referred to medical 26	1 ☐ Yes		33 No
	Physician: this certific	To B	examiner:	100	esidence 6 Other (Specif	iy)
13/	Jing P. After ti	on:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at Work?	_	e how injury occurred	
42/C	Attending r death. ctor: After by the fune	cat	3 Suicide 6 Could not be 280 Bloom of Injury. At home, form street feature of	2 No	(Street and Number or Rura	of Courts Museum
J. ic	after after Direction	Certification:	4 Homicide determined building, etc. (Specify)	City or 1	Town, State)	ir Houle Number,
	To the Hospital or Attent within 24 hours after death To the Funersi Director: completely filled in by the		29a. Certifier (Check only   Check only   Ch	date and place, and due to the	ra cause(s) and manner as s	latau,
	the H hin 24 the F nplete	Medical	and mariner stated.			
	viit To	-	29b. Signature and title of certifier C. Bruch, MuA. 29c. License nu	16940	29d. Date signed (Month,	* * * * * * * * * * * * * * * * * * * *
	STIVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D MEMORY	AL HOSPETI	H, 501
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	UE, HAVRE	DE GRACI	= 21078
	Sta Registr		FEB 0 2 2009 Sure B. Spare	,		•
		_	I LU V - LOVY / MANON 10. 189 MAN			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg No 2009

			For State Registrar	State of Mary	/land / De C	partment of F ertificate of	Health and M <i>Death</i>		2009	04429
	Physici /Medic		1. Decedent's Name (First, Middle, Last	Α.	SCH	EMANSK	.1	2. Date of Death Month	Day Year 2007	3. Time of Death
may.	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Death	
~	Funeval		Mandrin Chesapeak  5. Social Security Number 6. Se		Ouse n yrs. last birthda	Harwo		8. Date of Birth	Anne Aru	
	Funeral Director			M 27 F 87	Yrs. ASI DITITUE	Months Days	Hours Min.	(Month, Day, Ye	ear) Coui	place (State or Foreign htry) ington, DC
	yland how		10a. State 10b. County	10	c. City, Town or	Location			1	0d. Inside City Limits
	e Mar Ba-f sl	Director	Maryland Anne Aru	ndel	Ed	lgewater				1 □ Yes 2 🛣 No
	with th		10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Cour	itry?
	ns 23	Funeral	1615 Ruxton Road	12. Was Decedent Ever	in IIS 1	2103		naify Vala on Na	USA	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be rediffed at	Ş	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ▼ No	Specify:	Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	72 hor	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dec	cedent's Usual Occup	pation	165	b. Kind of Business/Ind	dustry
12	vithin ane. <b>:han</b> "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done of DO NOT use retired	dunng most of work!! d)	I		_
d 2	filed v Hygie other i	ဝင္ပ	12th 17. Father's Name (First, Middle, Last)		Sec	retary	18 Mother's Name	(First, Middle, Maid	ibrary of	Congress
/an	Aental Aental rked c	To Be	James Pizzare	lle				ry Fletch	,	
lar)	2 short and h is ma	-	19a. Informant's Name/Relationship (T)				and Number or Rura	al Route Number, Ci	ity or Town, State, Zip	
e, ≥	l and lealth		Doris L. Kline/ S:						olis, MD 2	
nor	ages ant of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	removal nom state		position (Name of ematory or other plac			c. Location - City or To	•
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		4 □ Donation 5 □ Other (Specify)  21. Signature (Signature Signature Signat			Crematory 22. Name and Addres			dgewater, alas Funer	
m	89 E 8 8	Ш	1 mal			2973 Solor	mons Islan	nd Rd. Edg	gewater. M	D 21037
	Physician /Medical		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a	y	nter the mode of dyin	such as cardiac o	r respiratory arrest,	2/	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a cor			/			
	nsit	Examiner	Sequentially list conditions, if any leading to infine diate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of).					
o^	tificate be executed ig physician and as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	<del> </del>				
09/89	cate by	edical		1						
×	1 0 K		IF FEMALE:	3c. If yes, outcome of pr	egnancy					
SO POS	e law requires that the death cer has been signed by the attendin e 2 should be detached for use.	Physician/N	23b. Was decedent pregnant in the past 12 gronths? 1 □Yes 2 □No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		23d. Date of delive Month	ry Day Year
ras, r	The law requires that the ate has been signed by th bage 2 should be detache	2	Part II. Other significant conditions cor	tributing to death but not	t resulting in the	underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to th	
ecord	aw rec as bee 2 shou	plete						24a. Was an		sy findings available
֓֞֞֞֜֞֞֜֞֜֞֜֞֜֞֜֞֜֜֞֜֓֓֓֓֓֓֓֓֓֓֡֟֝֜֝֓֡֓֓֓֡֜֝	age l	Completed						autopsy performed	prior to con death?	pletion of cause of
VITA	sician certifi rector,	Be	25. Was case referred to medical examiner?	ospital:	-	l out	26. Place of Death		MANO	pol
5	g Physer this eral di	٥	1 Yes 2 No ☐  27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		4 L Nursing Hon	ne 5 Residence 8d. Describe how in		HOSPICE AND
SION	ath. r: Aft	atio	Matural 5 Pending 2 Accident investigation	(Month, Day, Yea	ar) Injury	Work	? /es 2 \Bo	od. Describe now in	ijury occurred	
	or the rospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, i	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Abuilding, etc. (Sp.	At home, farm, s	treet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	Hospita 4 hours Funeral tely fille		(Check billy 2   Wedical Examir	sician: To the best of my	knowledge, dea	th occurred at the tim	ne, date and place, a	and due to the cause	e(s) and manner as st	ated.
	o the	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. License			Date signed (Month, £	
<b>)</b>	- > r= 0	1	MAN O M	Put y any		D	21438		Muary 2	62009
	3(,)		A Name and address of person who co	npleted cause of death	(Item 23a) (Type	Print) DEF	ENSE H	1 6 1+WAY.	ANNARUL	3 M DZIYU
	Stat Registra	-	31. Date filed (Month, Day, Year)  JAN 2 8 2009	37. Registrar's S	ignature B. La	west .				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 04430 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <sup>Day</sup>2009 Month Americo Ρ. Sesso A M January 26. 2:20 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Calvert Nursing Home Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 5, 1 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 578-09-6792 Director Washington, Usual Residence of Decedent 10a State 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examinar must be notified at Director 1 XYes 2 No Maryland Prince George District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 2204 Breton Drive 20747 USA Funeral items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 6 þ 1 □Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier 7 is marked other th Chief of Police City of District Heights 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John Sesso Lena Petrella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra George A. Sesso/ Son 170 Miss Sams Way, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2009 Suitland, Maryland 21. Signatural Sprvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. Mulle 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): attending physician use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Month Year 5 ☐ Other (specify). 1 ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗆 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. or Attending Physician: The

72 hours after

Pages 1 and 2 s ment of Health ar

Baltimore, Maryland 21215-0036

the as been signed by the should be detached certificate has After this To the nosperior within 24 hours after death.

To the Funeral Director: Aft

10/10

Registrar

31. Date filed (Month, Day, Year) State

(Check only one)

29b. Signature and title of certifier

Jonathan Lowenthal, M.D., 10845 Town Center Blvd., #204, Dunkirk, MD 20754 Registrar's Signature JAN 2 8 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

**ORIGINAL** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00871 State of Maryland / Department of Health and Mental Hygiene Casey Spence 2009 04431 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Day Month Spence Medical Examiner Casev January 29, 2009 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Ellicott City Howard 10206 Globe Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number Funeral Foreign Maryland Min. Months Davs Hours Director Sept.18,1988 M 2X F Yrs 20 216-21-9489 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Ellicott City permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygienc. Important: If item 21 is marked other than "natural", or items 23a or 28a-f sho Md. Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 10206 Globe Drive 21042 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XNever Married 2 Married Yes 2 X No specify: White Yes 2 X No specify: Widowed Divorced f Yes, Give Yea Δ 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) l other than "r the Medical E Student Education lyr. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carla Walden W. Mark Spence 2121 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W.Mark Spence/Father 10206 Globe Drive Ellicott City, Md. 21042 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/4/2009 Mt. View Cemetery Marriottsville,Md. Other Specify Donation 5 22. Name and Address of Facility 21. Stgnature of Funeral Service/Linensee Harry H. Witzke's Family F. H. Inc. MOO845 Md 21043 Approximate Interval 4112 Old Columbia Pike Ellicott City Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. /Medical a. Contact Gunshot Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical signed by the attending physician at be detached for use as the burial -UNPENDED AMENDED Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions P.O. þ Yes 2 V No 3 Probably 4 Completed Records, 24a. Was an 24b. Were autopsy findings available has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 No Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Hospital: 1 Other; examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient ER/Outpatient 3 this 1 ✔ Yes No 28a. Date of Injury (Month, Day, Year) Jan 29, 2009 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death Subject shot self 1522 hrs Natural Division Yes 2 V No Director: Pending 2

1529 hrs

Yes 2 X No

Between Onset and

Death

Year

Unknown

2 No

28f. Location (Street and Number or Rural Route Number, City

January 30, 2009

29d. Date signed (Month, Day, Year)

or Town, State) 10206 Globe Drive, Ellicott City, MD

OCME 2006

filled in by

To the l

Medica

State

Registrar

ave **ORIGINAL** 

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

(Specify) Single Family

and manner stated.

Assistant Medical Examiner

MARKERA

32. Registrar's Signature

31. Date filed (Mon

29b. Signature and title of certifier

Melissa Brassell, MD

Accident

Homicide 29a. Certifier

3 V Suicide

Investigation

Could not be

determined

rance 30. Name and address of person who completed cause of death (Item 23a)

			For State Registrar	State o	f Marylar		artment of F rtificate of		d Mental Hy	giene 0 0	9 04432
			1. Decedent's Name (First, Mide	dle, Last)					2. Date of Dea	ath	3. Time of Death
	Physic /Medi		Nyoka		Kay		Thomas	3	Januar	,	00 6:32 A M
1	Exami		4a. Facility Name (If not instituti	on, give street and nur	nber)		4b. City, Town, o	r Location of D		4c. County of	
			Allegany Co. N					rland		Alle	
н	Funeral		5. Social Security Number 164–44–3823	6. Sex	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Year Months Days		fin. (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	A	50				01/30	/1951   P	ennsylvania
	yland		10a. State 10b. Count	у	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	a-fs	cto	MD Al:	Legany		C	umberland	i			1 XYes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?
	ath w		407 Deca	atur Street			215			USA	
	er de Items	Funeral	11. Marital Status	Armed For		.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	hours after death with the Maryland tural", or items 23a or 28a-f show	by	1 ☐ Never Married 2 ☐ Ma 3 💢 Widowed 4 ☐ Divorce	If Yes, Giv	re <sup>1</sup>		1 □Yes 2√∑No	Specify:		Specify:	
9	"natural", or		15. Decede	nt's Education	ites.	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busir	White
215	within 72 iene. than "nal	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)	I (Give	kind of work done DO NOT use retired	during most of i	working		industry
21	d with	Ю	12	2	-401 ST)		Operator	2		Teleph	one
nd	be filed within 7: ntal Hygiene. ed other than "n event, the Medi	Be (	17. Father's Name (First, Middle	, Last)			•	18. Mother's I	Name (First, Middle,		
yla	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Inc Me	ုင	Glenwood		Tall			Pearl		Mill	
Maryland 21215-0036	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relation						Rural Route Numbe		
	es 1 and 2 of Health a item 27 ls r other tra		Margaret K. Th	omas-Aquil					Jacksonvi		
Baltimore,	permit. Pages 1 Department of I Important: If ite any Injury or ot		1 ☐ Burial 2 🎇 Cremation	3 Removal from S	State 200. F	cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location - Cit	y or Town, State
Ē	permit. Pa Departmen Important: any Injury		4 □ Donation 5 □ Other (			berlan	d Cremat	ory 101/	30/2009	Cumberla	and, MD al Home, P.A.
Ba	Depa Impo any I	U	Kene &	Udoing	5				eet, Cumbe		
			23a. Part 1. En the disease, of shock, or heart failure. Lis	complications that ca t only one cause on ea	aused the deat ach line.	h. Do not ent	er the mode of dyir	ng, such as card	diac or respiratory are	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a MU	-TIPL	E S	CLER	0515			Onset and Death
4	/Medical Examiner		resulting in death)	Due to (	or as a conseq	uence of):					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a conseq	uence of):					
	od d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events	<b>S</b> .							
o,	e exectan ar	EX	resulting in death) Last	Due to (c	or as a conseq	uence of):					
8760,	cate be executed physician and the burlal-transit	dical		d							
39	ertific ling p e as t	1 (D) 1	IF FEMALE:								
Box	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 Feta	ideath 3 □	Ectopic pregnanc	y		23d. Date o	
P.O.	he de / the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 □ Pregn 9 □ Unkno	ant at time of o	leath 5	Other (specify) _			WOTH	Day real
Ф.	that the bed by detax	-P	Part II. Other significant condit	ions contributing to de	ath but not res	ulting in the ur	derlying cause give	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
Records,	Physician: The law requires that the death certificate that been signed by the attending in director, page 2 should be detached for use as	d by							1 □ Ye	es 2 <b>1 N</b> o 3[	☐ Probably 4 ☐ Unknown
000	w rec	Completed			-				24a. Was a	n 24h Wei	re autopsy findings available
æ	rhe law te has age 2 s	E O							<ul> <li>autops perfori</li> </ul>	sy prio med? dea	r to completion of cause of th?
Vital	ysician: The iis certificate hi director, page	BeC	25. Was case referred to medica	al				26 Place of F	1 ☐ Yes Death (Check only on		Yes 2 No
<b>f ∨</b>	nyslc nis ce direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Ir	patient 2 🗆	ER/Outpatien	t 3 DOA Othe	ar.	g Home 5 ☐ Reside		(Specify)
n of	<b>ದಾ</b> 0 0	崩	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date o	f Injury n, Day, Year)	28b. Time of Injury	28c. Injury Work			ow injury occurred	ореску)
Sio	eath. or: A the fu	atic	2 ☐ Accident invest	igation		,,		Yes 2□No			
Division	or At fter d direct in by	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place of buildin	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
	pital ours a eral C		29a. Certifier 1 <b>X</b> Certifyi	N The state of the					11		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	Medical	(Check only one)	ng Physician: To the l Examiner: On the ba and mann	sis of examina	tion and/or inv	estigation, in my o	ne, date and pla pinion, death o	ace, and due to the c ccurred at the time, d	ause(s) and mann ate and place, and	er as stated. due to the cause(s)
	To th withir To th comp	₩ E	29b. Signature and title of certific		/		29c. License	e number	2	9d. Date signed (M	fonth, Day, Year)
	3		1 Colouts	tus V. 1/2	saven	Q KM	2 DC	014865		January	30, 2009
	)		30. Name and address of persor	who completed cause	of death (Item	23a) (Type, F	Print)				
	MAS		Robustian	J. Barrer	a, M.D	., 50	O Memoria	ıl Avenu	ue, Cumber	land, MD	21502
	Sta	te	31. Date filed (Moath Pay Year	2009 202. Re	gistrar's Signa	ture franch	the de				
	Registr	वा		1	-	40					

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1910 P January 28, 2009 Louis David Wray /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 579-94-1129 XX 45 December 23,1963 WashingtonD.C Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Charles Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7840 Tall Oaks Place 20622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo White Specify Completed by 3 ☐ Widowed 4 🙀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the state Auto Mechanic Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant. If item 27 is marked oth Be Douglas Leon Wray, Sr. Cynthia Anne Houghton ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shaina Nicole Rodriguez/Daughter 934 Copley Ave., Waldorf, Maryland 20602 item 27 20b. Place of Disposition (Name of cemetery crematory or other place) Date Christ Church Cemetery February 3, 1 

Burial 2 □ Cremation 3 □ Removal from State = 0 permit. Page Department of Important: If any Injury or 4 Donation 5 Other (Specify) 2009 Accokeek, Maryland
22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A Accokeek, Maryland 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 M0081 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition Physician Ldupathic Immediat resulting in death) /Medical Due to (or s a consequence of): TALL Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of): physician Physician/Medical the as attending for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No ed by the detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2XNo 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a Was an certificate has t irector, page 2 s autopsy performed? death? I XYes 2□ No Attending Physician: 25. Was case referred to medical examiner?
1 □ Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ္ရ 1 🗹 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of perso

31. Date filed (Month, Day,

32. Registrar's Signature

leted cause of death (Item 23a) (Type, Print)

29c. License number

Dr

29d. Date signed (Month, Day, Year)

Prince Frederick MD 20678

ela Denise Wi		ns State	of Maryland	Depar // Depar	tment of ificate of	Health and Death	i Mentai F	nyglene Reg	No. 2	009 0443				
Physiciar	R	egistrar . Decedent's Name (First, Middle,Las	it)		- Indute of		1	2. Date of Death		3. Time of Death				
dical Examin	-	Angela Denise Wi						January 7, 2	2009					
	4	a. Facility Name (if not institution, giv 900 Lake Street	e street and number)		4	b. City, Town, or Salisbury	diz	野(田)	Wicomico	V.				
Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Yea  Months Days				Foreign				
Director		219-82-7174	M 2 X F	44	Yrs			March 9	, 1964	Country) MD				
		Usual Residence of Decedent		Ino City 7	Fown or Locati	OD				10d. Inside City Limits				
w any	ł	10a. State 10b. County		1		011				1 X Yes 2 No				
land f sho	힐	MD Wicomi	<u>co</u>	Sali	sbury	10f, Zip Code		. 10	g. Citizen of Wha	at Country?				
Mary r 28a- ed at	Director	10e. Street and Number				21801			1	USA				
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	1	900 Lake Street  11. Marital Status	12. Was Decedent	t Ever in U.S	3. 13. Wa	s Decedent of His	spanic Origin? (	Specify Yes or No-	14. Race - American Indian, Black,					
ath wi	Funeral	1 Never Married 2 XMarrie	d Armed Forces'		If Y	es, specify Cuba	n, Mexican, Pue	rto Rican, etc.)	White,					
ter de		3 Widowed 4 Divorce	1 Yes 2	A NO		Yes 2 X No			Specify:					
urs af Itural amin	d b	15. Decedent's Education (Specify of	only highest grade cor	mpleted)	16a. Deceder	nt's Usual Occupa lost of working life	tion (Give kind o	of work done retired)	16b. Kind of Bus	izen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: Black Kind of Business/Industry  City or Town, State, Zip Code)  Springs, GA 30127  Location - City or Town, State  Fruitland, MD  The AD 21801  Approximate Interval Between Onset and Death				
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	July 1	Cler			Dent of	County of Death Vicomico  DD/YYYY  9. Birthplace (State or Foreign Country) MD  10d. Inside City Limits 1 X Yes 2 No  Zen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: Black Kind of Business/Industry  pt of Motor Vahicles 1 Surname)  City or Town, State, Zip Code)  Springs, GA 30127  Location - City or Town, State  Pruitland, MD  10d. Inside City Limits 1 X Yes 2 No  2 No  14. Race - American Indian, Black, White, etc.  Specify: Black  Kind of Business/Industry  pt of Motor Vahicles 1 Surname)  City or Town, State, Zip Code)  Springs, GA 30127  Location - City or Town, State  Pruitland, MD  10d. Indian Provided Interval Between Onset and Death  11 Death  12 Approximate Interval Between Onset and Death  13 Death  14 Vear  15 Vear  16 Vear  17 No 3 Probably 4 V Unknown  17 Indian Probably 4 V Unknown  18 Indian Probably 4 V Unknown  19 Indian Probably 4 V Unknown  19 Indian Probably 4 V Unknown  24b. Were autopsy findings available prior to completion of cause of death?  19 No 1 Yes 2 No  3 No  4				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		12				- Crer		me (First, Miaaie, M	_					
15-0 illed v Hygi d othe		17. Father's Name (First, Middle, Las	t)					Fenner	,					
d be femal	o Be	David Trader  19a. Informant's Name/Relationship	(Type, Print )		19b. Mailin	g Address (Stre	et and Number	or Rural Route Num	ber, City or Towr	n, State, Zip Code)				
MD 2 nd 2 shoul of the and h m 27 is m aumatic	၉	Michelle Trader/			2725	Adams La	anding W	lay, Powde	er Sprin	gs, GA 30127 _				
and 2 and 2 Health tem 2 traus	1	20a. Method of Disposition			Place of Dispo	sition (Name of co	emetery,	Date	20c. Location -	City or Town, State				
IOF gges 1 it of F t: If i		1 X Burial 2 Cremation 3				ry UMC (	cem   1/	/12/2009	Fruitl	and, MD				
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tr		4 Donation 5 Other Special 21. Signature of Funeral Service Lice	iy: ensee	-10-				Funeral E	-lome					
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Physician		23a. Part I. Enter the disease, or cor failure. List only one cause on	nplications that cause	ed the death	. Do not enter	the mode of dying	g, such as cardia	ac or respiratory arre	est, shock, or hea	Between Onset and				
/Mr. ical	10 7	Immediate Cause (Final disease	a. Subarcha	anoid	hemorr	hage				Death				
aminer	10.0	or condition resulting in death)	Due to (or as a con			n ourl cm								
	-	Sequentially list conditions,	b. Rupture			meurysm								
	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C.											
F. F.	Examine	events resulting in death) Last	Due to (or as a con	nsequence o	of):									
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Box 68760, e death certificate be- the attending physicia ed for use as the burit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo			etal death	Ectopic pre	egnancy						
x 68 h certi tendin use a	icia	past 12 months?	7	at time of de	eath 5	Other (Specify)								
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Division of the or Attending at the death.  I Director: After din by the fune	rtificati	3 Suicide 6 Could 1	ined (Specify)					the state of the state of	(-)	- a stated				
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		Registrar			Certificate of	Death		Reg. No. 2 0 0	04436
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	dical	Louis Frederic					Februa	-	5:20 A.M
Funera Directo	al	4a. Facility Name (If not institute Gilchrist Hosp 5. Social Security Number 212-36-6118	ice	ge (In yrs. last bir	TV	FLOCATION OF Death FOR SOIN FO	8. Date of Bi (Month, D	ay, Year) Co	
pu »		Usual Residence of Decedent		10. O't. T.					
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or 15	Director	10e. Street and Number		.1	10f. Zip Code			10g. Citizen of What Co	ountry?
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y a	ုင	Louis Frederic				Louise D	·		
2 sh 2 sh h and ris m		19a. Informant's Name/Relation	•	,	. Mailing Address (Street	and Number or Rui	rai Route Numb	per, City or Town, State,	Zip Code)
ges 1 and it of Healt if item 2		Dorothy Leona (1  20a. Method of Disposition  1 Burial 2 Cremation	nes Quinn) Avi	20b. Place of cemeter	23 Stablers  Disposition (Name of ry, crematory or other place	ce) Feb	Date	arkton Sary 20c. Location - City or	land 21120 Town, State
it. Pa Irtmer Irtmer Injury		4 □ Donation 5 □ Other		Evans	Funeral Cha	pel 200		Forest Hil	l, Maryland
Depa Depa Impo any l	ouce	21. Signature of Funeral Service	e Licensee	R.	22. Name and Addre	Alternativ	zes Fun	eral&Cremat	ion Ctr.,P.A
Physicia /Medica Examine	al er	23a. Pa E ter the dipa e, sick, rheart failur. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as	d the death. Do ine.	ont enter the mode of dyi	ng, such as cardiac	or respiratory a	n. Maryland urest, Ung disens	Approximate Interval Between
eath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	s a consequence					
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the 1 completely filled in by the funeral director, page 2 should be detached for use as the 1	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2  Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	<del>у</del>		23d. Date of de Month	livery Day Year
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The law re te has bee age 2 sho	Completed	millita	is, tong	CANCE	4		24a. Was auto perfe	psy prior to death?	utopsy findings available completion of cause of
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ding Physic  After this ce funeral direc	ion: To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend	28a. Date of Inju	ury 28b.	Atpatient 3 DOA Other	er: 4□ Nursing Hory at k?	ome 5 🗆 Resi	dence 6 Other (Spe	city) Hospice
al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Place of In	jury - At home, fa tc. <i>(Specify)</i>	M 1 ☐ 1 ☐ rm, street, factory, office	Yes 2 □No	28f. Location ( City or To	Street and Number or R wn, State)	ural Route Number,
he Hospit in 24 hour he Funera pletely fille	edical (	29a. Certifier 1 Certify (Check only one) 1 Medica	ring Physician: To the best al Examiner: On the basis of and manner st	ot examination an	e, death occurred at the tind/or investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
Tot Tot	Ž	29b. Signature and title of certif	by del	7. 01	(Type, Print)  (Type, Print)  (Type, Print)	se number		29d. Date signed (Mont	th, Day, Year)
117	/	30. Name and address of perso	y Game	670 (	(Type, Print)	St. Be	eto i	and Zeza	1>
Regi	State strar	31. Date filed (Month, Day, Yea FEB 17 20	109 Seresul	rar's Signature	arket				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 04437 Richard Lee Anderson, Jr.

		1- For State Certificat	te of Death	Reg	. No.	
Physicia		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Exami		RICHARD LEE ANDERSON, JR.		Month I February 11	Day Year I, 2009	1948 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	
		19570 Crystal Rock Drive	Gaithersburg	100	Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd		lrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birl	
Director		220.04.1029 1XXM 2 F 40	Yrs. Months Days Hours M	lin.	Foreig	
	-	220.04.1029	110.	MAY 30,	1968	untry) WV
any	1	10a. State 10b. County 10c. City, Town or	Location		-	10d. Inside City Limits
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Aaryland 28a-f show 1 at once.	휘	MD MONTGOMERY GERMANTO  10e. Street and Number	DWN 10f. Zip Code	1100	. Citizen of What Cour	atru?
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r dear or it	ᇍ	1 XX Yes 2 No			WHI	TE
s after ral",	à	3 XXWidowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2xx No specify:		Specify:	
15-0036 filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once			ecedent's Usual Occupation (Give kind our iring most of working life. DO NOT use r		16b. Kind of Business/I	Industry .
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21215-0036 wild be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner.	Be			T LOUISA GIL		~ ~
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re, MD 2 1 and 2 shou 7 Health and 1 fitem 27 is rest traumatic			58 DAMASCUS RD., DAMAS			T 61.11
ore, M ges 1 and 2 t of Health : If item 2			Disposition (Name of cemetery, y or other place)	Ďate	20c. Location - City or	rown, State
Page ent o			CEMETERY FI	EB 18, 2009	ELKVIEW, WV	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	1	21. 5 ha tre of Funeral S Anci Livensee	22. Name and Address of Facility		,	
E P P E		K. XGRECORY FINK MOT148	FINK FUNERAL HOME, P I 426 CRAIN HWY, S., G	.A.	MD 21061	
Physician		23a. Part I. Enter the discase, or complications that caused the death. Do not	enter the mode of dying, such as cardia	c or respiratory arres	st, shock, or heart	Approximate Interval
- /Medical	14	falure. List only one can se on each line.	rrhago			Between Onset and Death
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sit sq	Xa	events resulting in death) Last Due to (or as a consequence of):				
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	E	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 past 12 months? 4 Pregnant at time of death	Fetal death 3 Ectopic pre	gnancy	Month	Day Year
Box 68 e death certif the attending ed for use as	Sic	1 Yes 2 No 9 Unknown G Unknown	Other (Specify)			
P.O. Box 687 s that the death certific gned by the attending p	Physician/Medical	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I	23e. Did toh	pacco use contribute to	the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	Be			autops	y prior to	completion of cause of
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n of \ ling Phy After th funeral	-1	27 Manner of Death 28a Date of Injury 28h Ti	me of Injury 28c. Injury at Work?	_	ow injury occurred	
on ding	틸	1 Natural 5 Pending (Month, Day,Year)	1 Yes 2 No			
	Certification:	2 Accident Investigation 28e Place of Injury - 4t home farm	m, street, factory, office building, etc.	28f Location (St	treet and Number or Ri	ural Route Number, City
Divisipital or At ours after deral Direct filled in by	튑	3 Suicide 6 Could not be determined (Specify)	in, street, ractory, office ballating, etc.	or Town, Sta		arar reduce reamber, only
Div Hospital or 24 hours afte Funeral Dit	ပိ			1		
	cal	Certifying Physician: To the best of my knowledge, death one)  2  Medical Examiner: On the basis of examination and/or inv				
To the Hospital within 24 hours To the Funeral completely filled	Medical	and manner stated.		T T T T T T T T T T T T T T T T T T T		
	≥	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
		- Millims	O.C.M.E.		February 12, 20	U <del>9</del>
<u> </u>	l	30. Name and address of person who completed cause of death (Item 23a)				
A 1		Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201		
S	ate	31. Date filed (Moath, Day Year) 32. Registrar's Signature				
Regis	ror		have I			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** GEORGE 9:30 PM 09 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMIRE Somaritan Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours Months Days 213-30-4941 75 June 21, 1933 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinations to restited at Director 1 XYes 2 No MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2906 Westfield Avenue 21214 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ★es 2 No If Yes, Give Year or Dates: Navy 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White Specify \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook 12 Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental ဂ George J. Alban Sr. Emma Foley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once. 9628 Dundawan Road, Nottingham , MD 21236 Bridget Colclough / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 2/16/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ deud carcinomA 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 1 A Tim 1 ☐ Yes 25. Was case re erred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 NO 1 ♣ patient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner spated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of 29c. License number D0053722 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Summitan Hosp. Baltimore, MD PILLING - 32. Regis rar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene,

			For State Registrar	otato of marylan	Cei	tificate of l	Death	Re	g. No. 2009	04439
,	Physici	an	1. Decedent's Name (First, Middle, Last)	ADFI	MA	n1		2. Date of Death Month	Day Year	3. Time of Death 1:38 P M
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)	0 17	4b. City, Town, or	Location of Death	十七万。(	4c. County of Deat	
			312 BRYANSTONE				ERSTOWN		BALTIM	
H	Funeral Director		210-04-7002	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/11/1	9. Birti 957	hplace (State or Foreign untry) MD
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	the Marylar 28a-f show	ctor	MD BALTIMOR	E	REI	STERSTOWN	V			1 □Yes 2 No
	with the	Director	10e. Street and Number	OAD		10f. Zip Code	0.6	10	g. Citizen of What Co	untry?
	ms 23	Funeral	312 BRYANSTONE R	2 Was Decedent Ever in U.S.	3. 13. <u>\</u>	2113	Spanic Origin? (Spe In, Mexican, Puerto F	cify Yes or No-	USA 14. Race - Amer	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	l l	r Yes, specify Cuba I □Yes 2 🛣 No	Specify:	Rican, etc.)	Black, White Specify: Wh	e, etc. HITE
15-0	I within 72 ho giene. r than "natur ne wedical	letec	15. Decedent's Educ (Specify only highest grade	cation com <i>pleted)</i>	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	turing most of workin	g 10	6b. Kind of Business/I	ndustry
212	filed withir I Hygiene. other than ent, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			TECHNICI	AN	ELECTRO	NICS
pu	be filectal Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	ŕ	
ryla	2 should be f and Mental I Is marked ol raumatic eve	욘	JULIUS  19a. Informant's Name/Relationship (Ty)	ADEL		a Address (Chapte	RUTH	Davida Normalia	PROPE City or Town, State, Z	
	5 ¥ 7 ₹ 5		RUTH ADELMAN / MO	THER	5512	NORTHGRE	EEN ROAD,	BALTIMO	RE, MD 21	244
Baltimore,			20a. Method of Disposition  1	emoval from State 0HE MEM	lace of Dispo B SHAL ORIAL	sition (Name of DATE or other place PARK	02/13/		0c. Location - City or T	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	attle	22	. Name and Addres	ss of Facility SC		SON & BROS PIKESVILLE	., INC.
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the death e cause on each line.					T	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	KROBAN	SLE	MYOCA	ROIAL	NFAR	RTION	Onset and Death
7	Examiner			Due to (or as a consequ	ience of):	10N				75445
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):					
Mg	execut	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	****				
68760,	ertificate be executed ing physician and s as the burial-transit	Medical	<b>€</b> d							
9 X	certific		IF FEMALE:	3c. If yes, outcome of pregnal	ncv				22d Date of deli	
.O. Box	Attending Physician: The law requires that the death certificate be executed refeath. The third to death or death.  scior: After this certificate has been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other <i>(specify)</i>	/		23d. Date of deli Month	Day Year
s, P.	iires that signed b	by Pt	Part II. Other significant conditions con		Iting in the ur	iderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	v requir been s should	eted	CHRONIC OBSTRU	KITTLE LU	109 ]	11SEVASC			2 No 3 Pro	
Rec	he law te has l	Completed by						24a. Was an autopsy performe	ed?   death?	topsy findings available completion of cause of
ita	ician: The lav certificate has ector, page 2	Be Co	25. Was case referred to medical examiner?				26. Place of Death			2  No
of V	Physic this ce		1 ☐ Yes 2 No H	ospital: 1   Inpatient 2   I	ER/Outpatien		4 LI Nursing Horr		nce 6 Other (Spec	sify)
on	nding F tth. : After e funera	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	Injury	Work	/ at ? /es 2 □ No	8d. Describe how	injury occurred	
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office	2	Bf. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	re Hospita 24 hours re Funera sletely fille	dical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	n occurred at the tin restigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the vithing to the complete	Me	29b. Signature and title of certifier	1 Atronio	ING	29c. License			d. Date signed (Month	
	3	-	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)	0010	11	CIN COLINE)	2(11)
			31. Date filed (Month, Day, Year) FER 17200	23 (1055)201 32. Registrar's Signat	另)S 1	儿开致	1, DW11	VG5/VII	us, MI)	21/17
	Sta Registr	te ar	FEB 17 200		A	Wed .				
DIII	4H 47 Day 1/0/	201			6					

amend #5 PER Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** Month John Carroll Behr 02-12-2009 2047 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Secial Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-16-1919 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Months Hours <del>210</del>-01-6191 89 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Harford White Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2420 Island Branch Rd 21161 USA Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black. White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Bottling Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerard W. Behr Ruth T. Benhoff ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Behr (Wife) 2420 Island Branch Rd White Hall, MD 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 02-17, 2009 Pylesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Doingt enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequance 11) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): attending physician O. Box 68760 death certificate be Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Day 4□Pregnant at time of death 9□Unknown that the 9 Unknown signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No aw 24a. Was an autonsv The performe certificate Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14015 MG 508 Registrar's Signature 31. Date filed Month. Day. State Year Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 3:20 AM 2009 rebrieve 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor timore Dita a 1 Year | If Under 24 Hrs. Days Hours Min. Social Security Number If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1□M 2 F Months 220-14-5061 88 12/27/1920 Balt., Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No N/A Baltimore City Maryland 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21201 1 West Conway Street Apt. # 1415 America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No White Specify 3 ☐ Widowed 4 ☑ Divorced Ye ar or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Preston Jurney, Sr. Mabel Packham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 Putty Hill Avenue Parkville, Maryland 21234 Mr. Cary D. Sisolak/ grandson 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 16, 2009 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final piration disease or condition resulting in death) pneumous Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last POXIC Due to (of as a consequence of): sho Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat man be norther enems.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Be Completed by

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral circctor, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Certification: To Medical

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23	ic. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	I death 3 Ectopic		23d. Date of delivery Month Day Year			
Part II. Other significant condition	s cont	ributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?		
thy pertension	n				1 ☐ Yes	2 No 3 Probably 4 Unknown		
Chronic of	+1. >5+	part Failure F	re Showiv	i disease	24a. Was an autopsy performed 1 □ Yes 2 ₩			
25. Was case referred to medical		1		26. Place of De	ath (Check only one)			
examiner? 1 Yes 2 No	Н	ospital: 1 Inpatient 2	ER/Outpatient 3 ☐ I	DOA Other: 4 In Nursing	Home 5 ☐ Residence	e 6 ☐ Other (Specify)		
27. Manner of Death  1 Natural 5 Pending 2 Accident investiga		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred		
3 ☐ Suicide 6 ☐ Could no determin		28e. Place of Injury - At ho building, etc. (Specif	ome, farm, street, factory)	28f. Location (Street City or Town, St	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 ✓ Certifying (Check only 2 ✓ Medical E	Physi xamin	ician: To the best of my kno er: On the basis of examina	wledge, death occurre	ed at the time, date and place on, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		

29c. License number

South Hanovey St. Baltimore, MD

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AKTURO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signature

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Michael Baxter		State of Maryland							ible.	000	0 0111	. 1
		For State egistrar		cate of l			,,		g. No.	200	9 044	4 4
Physicia Medical Examir	n/	I. Decedent's Name (First, Middle,Last)  Michael Thomas Baxte				11,11		te of Death onth bruary 3		Year	3. Time of Death 1332 hrs	
Wedical Exami	_	ta. Facility Name (if not institution, give street and number		4b	. City, Town, or L	ocation of D		bruary o		County of Dea	th	ᅥ
( )		Anne Arundel Medical Center			Annapolis					ne Arunde		┙
Funeral	- 1		ge (In yrs. last t	oirthday)	If Under 1 Year Months Days	If Under 2 Hours	Min	ate of Birtl	h (MM/DI	0/YYYY) 9. B	irthplace (State or ign ountry) Maryla	
Director	L	217-70-2220   1X M 2 F	51	Yrs.	Monare Buye		N	ov.	4,	1957 0	ountry) Maly la	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Locatio	n					<del></del>	10d. Inside City Limit	s
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13658	Director	10e. Street and Number			10f. Zip Code 2121	7		10	g. Citize	n of What Co USA	untry?	
36 the Ma the Ma sa or 28		1365 N. Gilmor Street					0 / 0	V-a az Na			erican Indian, Black,	_
tems 2	Funeral	11. Marital Status 12. Was Deceder 1 X Never Married 2 Married Armed Forces	s?	13. Was	Decedent of Hisp s, specify Cuban,	Mexican, P	? (Specity uerto Ricar	res or No- n, etc.)		White, etc.		
ter de:		3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 X No	1	Yes 2 X No	specify:			s	<sub>peclly</sub> .lac	k	-
our: at	og p	15. Decedent's Education (Specify only highest grade co			s Usual Occupations of working life.			one		nd of Busines		٦
36 in 72 h han "n iical E	Completed	Elementary/Secondary (0-12) College (1-4 o 1 2th grade 1 Year	r 5+)		Cook				Pri	vate	Industry	
21215-9036 Mul. be filed within 7 Mental Hygiene. unarked other than c event, the Medica	ĕ	17. Father's Name (First, Middle, Last)			1	8.Mother's I	Name (Firs	t, Middle, N	Maiden S	urname)		
215 be file ntal H- rked o	Be	Thomas Baxter										
Baltimore, MD 21215-0036 permit Pages I and 2 shouls be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other trammatic event, the Medical Examiner must be notified at once	۴	19a. Informant's Name/Relationship (Type, Print) Ashton Baxter/ Brothe	r	19b. Mailing 1365	N. Gil	mor S	r or Rural Stree	Route Num Be		more,	MC 21217	
e, M and 2 Health ifem 2		20a. Method of Disposition	20b. Pla	ce of Disposit	ion (Name of cen	netery,	Dat	e / 0 0			or Town, State	
morages lant of lant if		1 X Burial 2 Cremation 3 Removal from 9 4 Donation 5 Other Specify:	Arbu	itus 1	er place)  Memoria	1 Pa:	rk/ 13	9/09			Maryland	-
Baltimore, pernit Pages I an Department of Hee Important: If iten injury or other tr		21. Signature of Firm rai Service Licensee		22. Na	ame and Address	of Facility	Chati	ກລຸກຸ-	ları Bali	ris Fu	neral Hone Md 2121	je
	4	23a. Party Enter the disease, o complications that cause	ed the death. Do								Approximate Interv	ral
₱hysician /Medical	_	failure. List only one cause on each line.  Immediate Cause (Final disease a. Intrace)									Between Onset ar Death	d
xaminer		or condition resulting in death)  Due to (or as a cor	nsequence of):	TO MIO E E								
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cor	nsequence of):									
20 .	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a cor	nsequence of):									
e executed sian and rial - transit		events resulting in deathy Last			000 07	7. (1) D	<del>11111</del>			,		
), be exec ircian a	Physician/Medical	X UNPENDED AMENDED 2	3a,2/,p	erm,E	g889 3/1	.0/09	11					
Box 68760, e death certificate be the attending physic of for use as the bur	n/Me	IF FEMALE: 23c. If yes, outcomes 23b. Was decedent pregnant in the		and the same of	al death 3	Ectopic p	oregnancy			. Date of deliv Month	ery Day Year	
X 68 th certification intending or use a	sicia	past 12 months?	at time of death	5 Oth	ner (Specify)				İ			
, Bc the dea y the a	Phys	Part II. Other significant conditions contributing to de		ulting in the u	nderlying cause (	given in Part	i.	23e. Did t	obacco u	ise contribute	to the cause of death?	
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be certificate has been signed by the attending physic ector, page 2 should be detached for use as the bur		<u> </u>						1 Ye	s 2	No 3 F	robably 4 🗸 Unknow	1
Division of Vital Records, ra after death as Attending Physician: The law requir as After death as Director: After this certificate has been sited in by the funeral director, page 2 should bed in by the funeral director,	Completed by				-			24a. Was autoj			autopsy findings availate completion of cause of	
eco he law ate has	duc								ormed? 2 ✔ No	death	? Yes 2 No	
Vital Rec ysician: The I his certificate director, page	BeC	25. Was case referred to medical examiner?			26.Place	of Death (C						
f Vit Physici r this c	70 1	1 Yes 2 No		R/Outpatient 28b. Time of I		Other <sub>4</sub>	Nursing Ho			ry occurred	her: Scene	
nofing l h : Afte e funer	ë.	27. Manner of Death  1 X Natural  5 Pending	ay,Year)	ob. Time of h	· ·   -	Yes 2 1		5000.100		,,		
risio r Atter er deal irector	ficat	2 Accident Investigation 28e. Place o	l f Injury - At hom	ne, farm, stree	et, factory, office t	ouilding, etc	. 28f			nd Number or	Rural Route Number, C	ity
Division of ' pital or Attending Ph ours after death filled in by the funeral	Certification:	4 Homicide determined (Specify)						or Town,				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit		29a. Certifier (Check only one) 2  Certifying Physician: To the best of Medical Examiner: On the basis of e	f my knowledge examination and	e, death occur I/or investigat	red at the time, d tion, in my opinior	ate and place n, death occ	ce, and due urred at the	to the cau time, date	se(s) and and pla	d manner as s ce, and due to	tated. the cause(s)	
To t with To t	Medical	and manner state 29b. Signature and title of certifier	ed		29c. Licens				_		Month, Day, Year)	
		Mill Com	NI		O.C.	M.E.			Feb	rua <b>r</b> y 4, 20	009	
		30. Name and address of person who completed cause Russell Alexander MD. Assistant Med			Penn Street	. Baltimo	re. MD 2	1201	-			
<u> </u>	tate	31. Date filed (Month, Day, Year) 32. Regis				,	-, 2					
Regis			p. 19	fares				OCME				

09-01355	
Roberto Barrera	

орено ваггега		I- For State Registrar	tate of Maryland		rtment of tificate of			Mental		eg. No. 2(	009 0444
Physicia Medical Examin		Decedent's Name (First, Midd ROBERTO BARRERA	tle,Last)	. =					2. Date of Dea Month February		3 Time of Death 2029 hrs
		4a. Facility Name (if not instituti Holy Cross Hospital	on, give street and number				Town, or Lo	ocation of Dea		4c. County of I	
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	ast birthday)	If Und	er 1 Year	If Under 24			9 Birthplace (State or Foreign
Director		089.78.2706	1 X XM 2 F	46	Yrs	Month s.	ns Days	Hours M	5, 1962	Country) EL SALVADOR	
any	ł	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Locat	tion					10d. Inside City Limits
Maryland 28a-f show 1 at once.	ţ	MD MONTG	OMERY	SI	LVER SPR		Code			10- Oili-o- of 18/1-ol	1 Yes 2 XXNo
ith the Maryland 23a or 28a-f sho notified at once.	Director	13412 ROXBURY RD	•			10f. Zip	20904			I0g. Citizen of What EL SALV	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 N	12. Was Decedent	?					Specify Yes or Norto Rican, etc.)	14. Race - A White, e	American Indian, Black, etc.
after des	by Fu		1 Yes 2	XX No	1 <b>XX</b>	Yes 2	No No	specify: SA	LVODOREAN	Specify: S	SALVODOREAN
136 thin 72 hours a ne. than "natura tedical Examin	ted b	15. Decedent's Education (Spi Elementary/Secondary (0-12			16a. Deceder during m			on (Give kind on OO NOT use r		16b. Kind of Busin	ness/Industry
0036 within 7: iene. er than	Completed	9		,	DELIV	ERY P			18 -		ORTATION
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be Co	<ol> <li>Father's Name (First, Middle ROBERTO BARRERA</li> </ol>					18		me (First, Middle, LAURA QUE	Maiden Surname)	
5 9 9 E 9	2	19a. Informant's Name/Relation	ship (Type, Print )					and Number o	or Rural Route Nu	mber, City or Town,	State, Zip Code)
<b>5</b> 2 <b>4 7 5</b>	ď	XAVIER A. BARRER			Place of Dispos crematory or ot	sition (Na	me of ceme	BALDWIN etery,	Date Date		ity or Town. State
Baltimore, lemit Pages I and Department of Heal Important: If item injury or other tra		1 X Surial 2 Crematic	Specify:	CEM	ENTER10	GENER	AL	-	B 24, 2009	CUSCATLAN	, EL SALVADOR
Ball permit Depart Impor		21. So f r of Funeral Service	407	M01148	/ F	INK F		HOME, P		MD 21061	
Physician /Medical		23a. Par I. Enter the discusse, of failing. List only one hause	r complications that caused e on each line.	the death.	Do not enter t	the mode	of dying, s	uch as cardia	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)	e a. Gastrointestina  Due to (or as a cons			<del></del>		-			Death
	Į.	Sequentially list conditions, if any, leading to immediate	b. Liver Cirrhosis  Due to (or as a cons	equence of	f):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cons	equence of	f);						
ecuted and - transit	اق آھا		d								
60, ate be ex hysician	Medical	UNPENDED  IF FEMALE:	AMENDED  23c. If yes, outcome	me of pregr	nancv					23d. Date of de	alivery
Box 68760, death certificate be executed he attending physician and d for use as the burial - transit		23b. Was decedent pregnant in past 12 months?	the 1 Live birth		2 Fe	etal death ther (Spe		Ectopic preg	nancy	Month	Day Year
Box he death the atte	Physician/I	1 Yes 2 No 9 Ur	S GIRIOWII	L L					00- 0:44		(1-1)
P.C es that igned	ठ	Part II. Other significant cond	itions contributing to deat	n but not re	esuiting in the t	unaeriying	g cause giv	en in Part i.			Probably 4 V Unknown
Division of Vital Records, lat or Attending Physician: The law requir rs after death.  In Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	Completed								24a. Was auto	psy pric	ere autopsy findings available or to completion of cause of
Reco	EOS.			_			<del> </del>		1 🗸 Yes		ath? ✔ Yes 2 No
Vital F hysician: this certific	o Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Unanital:	ent 2 🗸	ER/Outpatient			of Death (Che		Residence 6	Other:
ion of tending Pheeath.	-	27. Manner of Death	28a. Date of Inju (Month, Day,	ury (ear)	28b. Time of I	Injury	28c. Injury	at Work?	28d. Describe	how injury occurred	
/iSiO or Atten her deatl irrector: n by the	Certification:	2 Accident Inve	estigation ald not be	njury - At ho	ome, farm, stre	et, factory					or Rural Route Number, City
Division Hospital or Attence 24 hours after death Funeral Director:	Cert.	4 Homicide dete	ermined (Specify)						or Town,	<u> </u>	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Fineral Director: After this certificompletely filled in by the funeral director,	Medical	(Check only   Certifying F	Physician: To the best of maminer: On the basis of exa and manner stated.								
F 3 F 8	ĕ	29b. Signature and title of certifi				29	c. License				(Month, Day, Year)
	-	30. Name and address of person	n who completed cause of o	death (Item	23a)		O.C.M	I.C.		February 16,	2009
4 V		Ana Rubio MD. As	sistant Medical Exan	niner	111 Penn S	Street, F	Baltimor	e, MD 212	01		
Sta Registi	ate	31. Date filed (Month, Pay, Year)	7 2009 32. Régistra	r's Signatu	A. Sa	cellad	,				

OCME

	•	For State Registrar	316	ate of Ma	arylanu / L	•	rtificate of		and Me		g. No.	109	0444	
Dhusisis		1. Decedent's Name (First, Mide	dle, Last)						2	Date of Death	Day	Year	3. Time of Death	
Physicia /Medic			Pau1		n, Jr.					ebruary	7 13,	2009	10:08 P M	
Examine	er	4a. Facility Name (If not instituti		and number)			4b. City, Town, o		of Death		4c. County of Death			
		Gilchrist Co	enter 6. Sex	7. Ag	e (In yrs. last bir	thdav)	Tows		24 Hrs. 8	. Date of Birth		altin   9. Birth	IOTE place (State or Foreign	
Funeral Director		214-90-6401 Usual Residence of Decedent	1 M 2			Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, Feb 8,	Year) 1963	Cou	yland	
yland Now	ì	10a. State 10b. Count	у		10c. City, Tow	n or Lo	cation						10d. Inside City Limits	
a-f st	cto	Maryland Bal	timore		Coc	key	sville						1 □Yes 2 🕅 No	
ith the	Director	10e. Street and Number					10f. Zip Code			10	g. Citizen of	What Cou	ntry?	
s 23a		114 Sherwood				10.1		030	1-0-(0	t. W N.	USA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Ma</li><li>3 ☐ Widowed 4 ☒ Divorce</li></ul>	1 ☐ Never Married 2 ☐ Married				If Yes, specify Cuban, Mexican, Puerto R					ick, White,		
tural	ed	15. Decede (Specify only high		ar or Dates:	16a	. Dece	dent's Usual Occup	oation			6b. Kind of E		hite ndustry	
hin 72 9. an "na Media	Completed	(Specify only high Elementary/Secondary (0-12)		pleted) ollege (1-4or 5	i+)	(Give life.	kind of work done DO NOT use retire	during mosi d)	t of working					
d with	Com	12		n/a	.,	F	irefighte				Fire		ing	
be file tal Hy d oth	Be (	17. Father's Name (First, Middle	, Last)							First, Middle, M		,		
ould I I Men narke	ပ္	Robert Pau		own, S			0.00		lise			iller		
d 2 sh th and 7 Is m traum		19a. Informant's Name/Relation					ng Address (Street				•			
1 and Healt em 2		Susan B. Eise:	nnart/S	ister			Sherwood sition (Name of matory or other pla				Oc. Location			
Pages nent of nnt: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		al from State	- 1			i -	2/17/0		Cd d	M	(a1 a d	
permit. P Departme Importan any Injur once.		21. Signature of Funeral Service	-	DON NO	purane	L	alley Mer 2. Name and Addre emmon Fu	ess of Facilit	Home	of Dula	ney V	allev	Inc.	
20200		23a. Part 1. Enter the disease,	or complication	is that caused	I the death Do		O W. Pado					210	193 Approximate	
Physician /Medical		shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cau a	UNG	ne.	CE	R with						Interval Between Onset and Death	
Examiner		Sequentially list conditions	b											
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	₹	Due to (or as	a consequence	of):								
rificate be executed og physician and as the burial-transit	xan	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as	a consequence	of):								
e be e			L <sub>d</sub>											
tificate I ng physia as the b	ledical													
death ce	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 4	Live birth	of pregnancy 2 ☐ Fetal death t time of death		☐ Ectopic pregnand ☐ Other (specify) _	су				ate of deliv	rery Day Year	
that ned by deta	by Phys	Part II. Other significant condi	tions contribut	ing to death b	ut not resulting i	n the u	nderlying cause gi	ven in Part I.		23e. Did tob	acco use cor	ntribute to	the cause of death?	
quires en sign uld be										1 ☐ Ye	s 2 No	3☐ Pro	bably 4 Unknown	
The law requir cate has been s page 2 should	Completed									24a. Was an autopsy perform	egi?	prior to co death?	opsy findings available ompletion of cause of	
sician: The certificate rector, pag	Be C	25. Was case referred to medic	al					26. Place	of Death (	1 L Yes 2, Check only one	No	1 🗆 Yes	2 □No	
Physic this ce al direc		examiner? 1 □ Yes ≥ No	Hospita	al: 1 ☐ Inpatie	ent 2 ER/O	utpatie	nt 3 DOA Oth	ner: 4 □ Nu	ursing Home	e 5 🗆 Resider	nce 6 XO	her (Spec	in HOSPICE	
ng l	Certification: To	27. Manner of Death Natural 5 Pence 2 Accident inves		a. Date of Inju (Month, Da		Time o Injury	Wo	ryat rk? ]Yes 2□		d. Describe how	w injury occu	rred		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ertific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be rmined 28	e. Place of Inj building, et	ury - At home, fa c. (Specify)	arm, str	eet, factory, office		28	f. Location (Str City or Town,	eet and Num State)	ber or Rur	al Route Number,	
e Hospit 24 hours e Funera letely fille	Medical (	29a. Certifier (Check only one)  Certify  Certify  Medica	al Examiner: 🤇	n: To the best On the basis of and manner st	of examination at	e, deat	h occurred at the to estigation, in my	ime, date ar opinion, dea	nd place, ar ath occurred	nd due to the ca d at the time, da	use(s) and r ite and place	nanner as , and due t	stated. to the cause(s)	
Vithin To the comp	Me	29b. Signature and title of certif	ier	2			29c. Licen	se number		29	d. Date sign	ed (Month,	Day, Year)	
		Frende	1 Dec	U-0	elle	$\bigcirc$	79	560	43	C	1/40	4/0	1009	
10 1		30. Name and address of person	on who complete		leath (Item 23a)	(Type,	Print)	ntav	nBI	ud/ B	alte	MD	2004	
Sta		31. Date filed (Month, Day, Yea	r)	32. Registr	a s Signature	art								
Registra	ar	FEB 1720	09 Le	- Cours	D. 190	TA/CS	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (Fjrst, Middle, Last) 2. Date of Death 3. Time of Death 1411 09 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 204 Otis Drive Severn Anne Arundel If Under 1 Year Months Days Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9/14/1936 9. Birthplace (State or Foreign Hours 1 M 2 □ F 241-50-6675 72 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severn 1 ☐ Yes 2 A No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Otis Drive 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1961— If Yes, Give Year or Dates: 1981 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Specialist US ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archie Burkhead Beula Mofit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mal Son Burkhead 204 Otis Drive; Severn, MD 21144 / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 2/18/2009 | Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA; 1 2nd Ave SW; Glen Burnie, MD21061 Monz Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (rras a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 11 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

MD

Director

Funeral

þ

Completed

Be

2

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner mast be notified at

"natural", or items

of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, Inc. Medical.

permit. Pages 1 Department of H Important: if ite any injury or ot

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and burial-tran attending physician for use as the buria

Physician/Medical been signed by the should be detached ð Completed certificate has lirector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be ၉

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE:

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Certification:

27. Manner of Death 1 Matural 2 Accident

(Check only one)

29a. Certifier

3 Suicide 4 Homicide

29b. Signature and title of cettifier

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be

Hospital:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

1 □Yes 2 □ No

2 ER/Outpatient 3 DOA

28b. Time of

29c. License number

Other:

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

26. Place of Death (Check only one)

4 \Bull Nursing Home

2 🗓 No

28d. Describe how injury occurred

5 Residence 6 ☐ Other (Specify)

no completed cause of death (Item 23a) (Type, Name and address of person Print 441

1 ☐ Yes

Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

		1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death  State of Maryland / Department of Health and Mental Hygiene 2009 04446	)
Physici		1. Decedent's Name (First, Middle, Last)  BURKE-DANKO February 13, 2001 1500 M	
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	_
Funeral		The Johns Hopkins Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months Days Hours Min. (Month, Day, Year)  9. Birthplace (State or Foreign Country)	_
Director		214-96-4821   1   M 2   XF   7. Age (iii yrs. last birtiday)   Months   Days   Hours   Min.   9/4/1964   Maryland   Waryland   Waryl	
aryland show d at	ŗ	10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits   1 N/A   Baltimore   1 x Yes 2 □ No	
h the M or 28a-f notifie	Director	10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country?	_
ath with s 23a c	eral D	6013 Hunt Ridge Road 21210 USA  11 Market Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	_
Baltimore, Maryland 21215-0036 print. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1	
5-0C	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  16b. Kind of Business/Industry  Control of Business/Industry  Dept Health	
2121 I within liene. r than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Risk Management MD State Gov't	
Maryland 21215-0036 nd 2 should be filed within 72 hours aft this and Mental Hyglene. 27 is marked other than "natural", or traumatic event, the Medical Examir	To Be C	17. Father's Name (First, Middle, Last)  John P. Burke, Jr.  18. Mother's Name (First, Middle, Maiden Surname)  Constance Logsdon	
Tarylan 2 should be and Mental is marked of aumatic eve		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
re, N s 1 and r Health tem 27 other tr		Constance L. Kammar / Mother 8 Oakhampton Drive Lutherville, Maryland 21093  20a. Method of Disposition (Name of D	_
Baltimore, crmit. Pages 1 ar Department of Hea Important: If item any Injury or other give.		1 Burial 2 Cremation 3 Removal from State Hilltop Serv. Corp. 2/19/2009 Towson, Maryland	
Balti p rmit. Departm Importa any inju		21. Signature of Furbral Service tricensee 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road	
THE REAL PROPERTY.		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or a a consequence of):	_
Examiner	_	Sequentially list conditions, b.	
ansit and	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	
and and		resulting in death) Last  Due to (or as a consequence of):	
	fedical	d.	_
I Records, P.O. Box 6  The law requires that the death certif the has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   1   Nonth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   23d. Date of delivery   Month   Day   Year   25d. Date o	
'ds, P.O.  Lires that the d  signed by the  lid be detached	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Tes 2 No 3 Probably 4 Unknown	
O m m	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  24c. Was an autopsy findings available prior to completion of cause of death?  24c. Was an autopsy findings available prior to completion of cause of death?	
Vital Iclan: Certifical rector, p	Be	25. Was case referred to medical examiner?  Hospital: Viscosital 25. Place of Death (Check only one)  Other: 4 District And District An	_
g Phys er this c	<u>ان</u>	1  Yes 2 No	-
rision ttendin death. stor: Aft y the fur	ertification:	Z Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,	
Div ital or A irs after al Direc	Certi	Sulfuring, etc. (Specify)	
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page	edical	29a. Certifier (check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To the comp	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
16		30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)	-
100		31. Date filed (Month, Day, Year)  32. Registrar's Signature	7
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 7 2009	

DHMH 17 Rev 1/2001

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middl							<ol><li>Date of Dea Month</li></ol>	Day	Year	3. I me	of Death
an al	JANE C. B.	ACOW ELL	•					2	15	2009	10:1	15_ <sup>Ам</sup>
er	4a. Facility Name (If not institution	n, give street and ne	umber)		4b. City, Town, or	Location	of Death		4c. C	ounty of Death		
	9 Glenamov Ro	ad			Timoniu	m			Ba	altimore	9	
	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year	9. Birth	place (State	e or Foreign
	213-09-8384	1 □ M 2 X F	9	2. Yrs.	Months Days	Hours	14111.	March 28		/	yland	
	Usual Residence of Decedent											
	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							City Limits
Director	Maryland Balti	more	Tim	onium							1 ∐Ye	s 2 No
ie	10e. Street and Number				10f. Zip Code				109. Citize	n of What Cou	ntry?	
	9 Glenamoy Roa	ad.			21093					U.S.A.		
Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13.	Was Decedent of H		rigin? (Spec	cify Yes or No-	14	. Race - Ameri		
2	1 ☑ Never Married 2 ☐ Mar	ried Armed F	2 🔽 No					ican, etc.)		Black, White,	etc.	
ò	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	live Dates:		1□Yes 2XINo	Specify:			S	pecify: NHI	TE	
Completed	15. Deceder	it's Education		16a. Dece	dent's Usual Occup	ation			16b. Kind	of Business/In	dustry	
bie	(Specify only nighe Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	life.	kind of work done of DO NOT use retired	auring mos f)	st of working	9				
ē	12	Conlege	(1 40/ 01)	Admi	nistrativ	e_Ass	sistar	nt	Fede	eral Go	vernme	ent
BeC	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,	Maiden Si	urname)		
To B	Joseph Gregory	Bagwell				N	Mary 1	Lucia P	urce1	11		
_	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Numb	er or Rural	Route Numbe	r, City or T	Town, State, Zi	Code)	
					4 West 38							21211
	Michael Bagwel 20a. Method of Disposition	1 / Nepl	20h F	Place of Dispo	sition /Name of	i	Da			ation - City or To		_ 12 1 1
	1 🕅 Burial 2 ☐ Cremation		Ctoto T	emetery, crer	al Cenetery		22 20	-2009		imore, l		and
	4 □ Donation 5 □ Other (S		) INEW	_		1						
	21. Signature of Funeral Service	Licensee		/	. Name and Addre		Ruc			ineral !		Inc.
	Laway	aful	an		<u>1050 York</u>		-			and $21$		
	23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that only one cause on	caused the deat each line.	h. Do not ent	er the mode of dyir	ng, such as	s cardiac or	respiratory ar	rest,		Approxim Interval B	ate etween
	Immediate Cause (Final disease or condition	C	HRONLC	OBSI	PUCH VE	Tu	LMO	NAMY 1	DISE	TSE	Onset an	d Death
	resulting in death)		o (or as a conseq								10111	
					MANIN						YEM	rs
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	o (or as a conseq									
Ē	Cause (Disease or injury that initiated events		DOMENT	7 A							YE	TRS
Examiner	resulting in death) Last	Due to	o (or as a conseq	uence of):								
		d										
eaic		u.										
cian/Medical	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna						23	d. Date of deliv	erv	
	in the past 12 months?		e birth 2  Feta gnant at time of c		☐ Ectopic pregnanc ☐ Other <i>(sp</i> ec <i>ify)</i>	У				Month	Day	Year
2	1 □ Yes 2¥ No 9 □ Unknown	9 ☐ Unk		36								
- L	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I	l.	23e. Did to	bacco use	e contribute to t	he cause o	of death?
by	HY POTHYRUI							1 □ Y	es 2	No 3∏ Pro	bably 4	Unknown
šec	1.	7		-					- 1	. 30.10		
Completed				_				24a. Was a		24b. Were auto	opsy finding	
DO.								perfor		death?	·	
BeC	25. Was case referred to medica	ıl				26. Place	e of Death	(Check only or				
	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nı	ursing Hom	ne 5 X Resid	ence 6	□ Other (Speci	fv)	
Certification: 10	27. Manner of Death	28a. Dat	e of Injury	28b. Time o	f 28c. Injur	y at		8d. Describe h			.97	
3	1X Natural 5 ☐ Pendir 2 ☐ Accident investi	19	nth, Day, Year)	Injury	M 1 🗆	k? Yes 2□	]No					
3	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At he	ome. farm. str	eet, factory, office			8f. Location 75	treet and	Number or Rur	al Boute Ni	umber
5	4 ☐ Homicide detern		ding, etc. (Specia		,,,			City or Tow				
	29a. Certifier 1 🗷 Certifyi	ng Physician: To th	an bast of my kno	wiedge dest	h occurred at the ti	me date a	and place a	and due to the	causa(s) s	and mannor as	etatad	
2		Examiner: On the	basis of examina									e(s)
Medical	29b. Signature and title of certific		inner stated.		29c. Licens	e number			29d Date	signed (Month,	Day Voor	-)
•		Ronal	el un				06	'				ì
	- rame	20,21,40	,000		0.2	72	01		die	116/2	00-1	
	30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type,	Print)	a n	Ca 24-	to 110	140	Lega XIII A	s n	D
	30. Name and address of person	+. SAVAI	EZ,MC	n 23a) (Type,	155 PALL	-5 R	OND	+200	un	tenvill	E, 2	1013
ite	30. Name and address of person PATRICIA 31. Date Tiled (Month, Day, Year	+ SAVAL	Registrar's Signa	n 23a) (Type,	Print) 155 PML	-5 R	OND	+200	un	HENVILL	€, n 2	1013

31. Date filed (Month, Day, Year)
FEB 1 7 2009

Baltimore, Maryland 21215-0036	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland safter death.  Department of Health and Mental Hygiene. I Director: After this certificate has been signed by the attending physician and rich in by the funeral director, page 2 should be detached for use as the burial-transit
	Physicia /Medica Examine
Division of Vital Records, P.O. Box 68760,	ne Hospital or Attanding Physician: The law requires that the death certificate be executed in 24 hours after death. he Funeral Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		For State Registrar		State of	Marylan		artment of F rtificate of	dealth and l Death		giene Reg. No.	/ 1 1 1 1 4	0444	8
Physicia /Medic		1. Decedent's Name	e (First, Middle, La	st)			Bown	an	2. Date of De Month	Day	2th Year 200	3. Time of Deat 9 1105 A	
Examin		4a. Facility Name (I			ber)		4b. City, Town, o	r Location of Death		4c. County of Death Baltimon		-	
Funeral Director		5. Social Security N 216-30-	8645	Sex M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	ay, Year)	9. Birti Co	hplace (State or For untry) MD	əign
show	_	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo						10d. Inside City Lin	
8a-f	Director	MD	NA			Balti	_			40 011		23	
3a or 2		10e. Street and Nur 3409 Jo		ve			10f. Zip Code	21244		10g. Citi:	zen of What Co	•	
arrer dear or items 2 miner mu	Be Completed by Funeral	11. Marital Status	ied 2 Married	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give	ces?	1	Was Decedent of H fYes, specify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, White	e, etc.	
perfinit. Fages I and 2 should be filled within 72 thous after death with the Marylan Importament of Health and Mental Hygiene. Important: If them 27 is marked other than "natural;", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		3 D Widowed	15. Decedent's E	Year or Dat		16a Decer	dent's Usual Occur	nation			Specify: nd of Business/l	Black	
		(Special Secondary (Secondary (Se	cify only highest gra	de completed) College (1-4	4or 5+)	(Give life, L	kind of work done  OO NOT use retire	during most of wor d)	king	Wes	tern (	Jnion	
ed with		12th gra	ade	na		(	Office_		(F) ( A4) 4 (		legrap	h Co.	
intal H ed ott		17. Father's Name		)				18. Mother's Nan			Surname)		
mark mark	၉	Acre Bo	wman ame/Relationship (	Type. Print)				and Number or Ru	ıral Route Numb	er, City or			
and 2 staffth an 127 is er trau			ne Bowm		9	3409	Joann I	orive, E	Baltimo	re,	Md 21	244	
of He		20a. Method of Dis	position ☐ Cremation 3 ☐	Removal from Si	20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Lo	cation - City or	Town, State	
tment tant: I		4 ☐ Donation	5 ☐ Other (Special	<i>(y)</i>	Gar			Vet 2	/18/09	Ow	ings M	ills, Mo	<u>E</u>
Depar Depar Impor any in		21. Signature of Fu	uneral Service Lice		- 10-	Ma	Name and Address F/E	H West				01015	
		23a. Part 1 Enter t	the disease, or com art failure. List only		use the deat	1 43	300 Waba	ash Ave.	Balti c or respiratory a	mao rrest,	re, Md	Approximate	
hysician		Immediate Cause	(Final					dder Ca				Interval Between Onset and Death	
/Medical		disease or condition resulting in death)	on 🕜		r as a conseq		106 1714	U007 CU	VICO1				
xaminer		Sequentially list co	nditions.	b									
nsit	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or	nmediate erlying injury	Due to (o	r as a conseq	uence of):							
physician and the burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequence of):											
nysicia ne bur	ledical		•	d									
ling pt e as tt	Med	IF FEMALE:											
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending tompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months?		rth 2 ☐ Feta ant at time of o	ıldeath 3□	Ectopic pregnand Other (specify) _	СУ	2	23d. Date of delivery Month Day Year			
ned by detac		Part II. Other signif	ficant conditions	contributing to dea	ath but not res	ulting in the ur	underlying cause given in Part I. 23e. Did tobacco use co					the cause of death?	>
en sig	ed by	Prosto	ate Car	rer					10	Yes 2	□No 3□Pr	obably 4 🖫 Unkno	wn
as be	Completed	Motas	static 1	Brain C	ance	<i>y</i>			24a. Was	DSY	24b. Were au	topsy findings availa completion of cause	ble
cate h	Con								perfo	rmed? 2 ⊠No	death?	2 No	
certifi	Be	25. Was case refer examiner?		Hospital:			ot 3 🗆 DOA Ott	26. Place of Dea			SEASO	INS HOSPICI	_
ar this aral di	2.10	1 Yes 2 X 27. Manner of Deat		28a. Date of	patient 2  f Injury	28b. Time of	28c. Inju	ry at	lome 5 Resi			ONS HOSPICE	,
ath. r: Afte e fune	atior	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigatio	(Month	, Day, Year)	Injury	Wor	rkí? ]Yes 2.∐No		, ,	,		
after des	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	1 28e. Place C	of Injury - At he g, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office	-	28f. Location ( City or To	Street and wn, State)	d Number or Ru )	ıral Route Number,	
n 24 hours n 24 hours ne Funera	Medical (	29a. Certifier (Check only one)	1 Certifying Pl	nysician: To the bar miner: On the bar and manne	sis of examina	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)	
Withi To th	M	29b. Signature and	title of certifier	Purten			29c. Licens			29d. Dat	e signed (Month	n, Day, Year) 2th 2009	r
11		30. Name and add	ress of person who	completed cause	of death (Iter	n 23a) (Type,	Print)	NE SUTE	203 Ba	thm	ore ML	2th 2009 21209	
Sta Registr		31. Date filed (Mon	172009	32. Re	gistrar's Signa	gark	,						

State Registrar 29b. Signature and title of certifier

31. Date filed (MoMir, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Ph.D.

32.

Registrar's Signature

29c. License number

RES -000

29d. Date signed (Month, Day, Year) 02:14.2009

09-	-009	959		

Michael Wayne Br	1	kS - For State Registrar	State	of Maryla		partment of ertificate of			Ment	al Hy	_	Reg. N	2 (	חר	a n	1.1.5
Physician	1	Decedent's Name (First,	Middle,Last)	)						1	2. Date of De	eath	-	JU	3. Time of [	Death
Medical Examine		MICHAEL W.	BROOK	S							Month Februar				1218 h	nrs
	ľ	4a. Facility Name (if not ins 8611 Castlemill C	, ,	street and nur	mber)		4b. City, To Notting		ocation of	Death	p in	ľ	4c. County o Baltimore			
Funeral		5. Social Security Number	6. Sex	(	7. Age (In yrs	s. last birthday)			If Under		8. Date of I	Birth (MI	M/DD/YYYY)	g. Birt Foreig	hplace (Stat	te or
Director		218-58-3346	1 <u>X</u>	M 2 F	57	Yrs	Months	Days	Hours	Min.	OCT.	1,	1951		untry)	MD
any		Usual Residence of Deceder 10a. State 10b. Co	<del> </del>		10c Ci	ty, Town or Locat	tion								10d Inside	City Limits
*	1		ALTIMO	ND E												2 X No
Aaryland 28a-f show Lat once.	3	10e. Street and Number	TLITIMO	KE	N N	OTTINGHA	10f. Zip (	Code				10a. C	itizen of Wh	at Cour		2 11 110
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f short transmatic event, the Medical Examiner must be notified at once.	1	8611 CASTLE	IIII. C	TRCLE								_				
with the rest of rest		11. Marital Status		12. Was Dece	edent Ever in	U.S. 13. Wa	212 as Deceden		anic Origi	n? ( Spe	cify Yes or I	LUSA No-		Ameri	can Indian, I	Black,
r death with or items 23 must be no	5	1 Never Married 2	XMarried	Armed Fo	rces? X No	If Y	es, specify	Cuban,	Mexican,	Puerto F	Rican, etc.)		White		HITE	
after all, o	3 Widowed 4 Divorced If Yes, Give Year or Dates:					1	Yes 2	No	specify:				Specify:	WI	ILIE	
hours finatur Exam		15. Decedent's Education					tent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)				16b	. Kind of Bus	iness/I	ndustry		
36 nin 72 than " dical	5	Elementary/Secondary (0	-12)	College (1-	-4 or 5+)	ETMA	NOTAT	ATST	7T.G.O.D.							
21215-0036 build be filed within 72 hour Mental Hygiene marked other than "nature event, the Medical Example of the Commission of the Comm	┋├	17. Father's Name (First, M	ddle, Last)			FINA	NCIAI				First, Middle	T. Maide	LS FIN en Surname)	IANC	JAL S	ERVICE
215 be file nital Hy riked o	I	FERRIE C. BR											BROOKS			
21 hould hould is maintic even	2	19a. Informant's Name/Rela	tionship (Ty						and Numb	er or Ru	ıral Route N	lumber,	City or Town	, State		
e, MD 21215-0036  I and 2 should'be filed within 72 hours at Health and Menial Hygiene item 27 is marked other than "natural r transmatic event, the Medical Examin TO Be Commisted by	44	MICHELE BROC	KS-WI	FE		86	11 CA	STLE	EMILL	CIR	RCLE	BAL'	TIMORE Location -	M	D 212	36
S 45 = 81	-	20a. Method of Disposition  1 X Burial 2 Cren	ation 3	Removal fro		<ul> <li>Place of Dispos crematory or ot</li> </ul>	sition (Nam her place)	e of cem	etery,		Date	200	c. Location -	City or	Town, State	
Baltimo permit. Page Department c Important: injury or ott	L	4 Donation 5 Oth	er Specify:			GARDENS				2/	6/09		BALTI	MOR	E. MD	
Salt remit Depart mpor njury	1	21. Signature of Funeral Se	vice Licens	ee			Name and A		-				EL FUN	ERA	L HOME	Ξ
Physician	1	3a Part I Enter the disea	e or compli	cations that ca	used the dea	ath. Do not enter t	6415	BELA	IR R	D rdiac or	BALTI	MORI	E. MD	212		ate Interval
/Medical		3a. Part I. Enter the diseal failure. List only one of							don do ca	I diac or	copilatory e	arrest, 3	riock, or riea		Between	Onset and eath
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i.		if any, leading to immediate cause. Enter Underlying C	ause	Oue to (or as a	consequence	e of):										
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executed an and all - transit	┇┞		d	0.	107	20- 6	MT	- (	000 2	/16/	/AA TPT				<b></b>	
be experience of the control of the		X UNPENDED		AMENDED2-	3a, <b>5</b> 2/	,28a-f,	perme	, go	389 3	/10/	09 11					
of Vital Records, P.O. Box 68766 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phynemial director, page 2 should be detached for use as the burn. To Be Completed by Physician/Met.		F FEMALE: 3b. Was decedent pregnan	in the	23c. If yes, o	utcome of pro		tal death	3	Ectopic	nreanan	CV	2	3d. Date of o		)ay	Year
box 6876 the death certificat by the attending phyched for use as the Physician/M	2	past 12 months?			ant at time of	death	her (Speci		Lotopio	pregnan	oy.		World	L	ay	Teal
Bo le deat the at the at led for	<u> </u>	1 Yes 2 No 9	Unknown	g Unkno	wn											
i, P.O. Box 6876 ires that the death certificat signed by the attending ph the detached for use as the dby Physician/M		Part II. Other significant co	nditions	contributing to	death but no	t resulting in the t	underlying o	ause giv	en in Parl	t I.			o use contrib			
Records, P.( The law requires tha ficate has been signed to page 2 should be detent to completed by	3												No 3			
Division of Vital Records, bluvision of Vital Records, rader death.  To director: After this certificate has been sited in by the funeral director, page 2 should the raffication: To Be Completed												opsy form <u>ed</u>	pr		topsy finding ompletion of	
tal Rection: The lectificate lector, page	5										1 🗸 Yes			✓ Ye	s 2 [	No
Vital ysician: his certif director,	2 ا د	25. Was case referred to me examiner?	_	ospital:				10	of Death (Cothera		-					
of Ving Physi ng Physi After this meral dir		1 Yes 2 No		п п	npatient 2	ER/Outpatient			at Work?		Home 5		dence 6 🗸		Scene	,
on of National Physics of the Community		1 Natural 5	Pending	28a. Date of (Month,					s 2 X I	- 1	subjec	t d	river	of		le in
risior r Attend er death rrector: by the		2 X Accident	Investigation	28e Place	/ 2009 of Injury - At	home, farm, stre					28f. Location	(Street	r acci	r or Rui	ral Route Nu	ımber, City
Division of spital or Attending spital or Attending nours after death.  neral Director: After filled in by the fune Certification:		3 Suicide 6 Homicide	Could not be determined	e (Specify)		dway			J.		or Town Fodd A	, State)	Rte. 4	0 p	ast	,
		Qa Certifier	ng Physicia	n: To the best	of my knowle	edge, death occur	red at the t	ime, date	e and plac				and manner	as state	d.	
To the II. within 24 To the Fi	3 6			On the basis of and manner sta		and/or investiga	tion, in my	pinion,	death occu	urred at	the time, da	te and p	lace, and du	e to the	cause(s)	
	2	29b. Signature and title of c						License		000	l d pm	29d	I. Daté signe	d (Mor	th, Day, Yea	r)
		Theodore V	4. Ku	TR.	min.			O.C.M	l.E.	001	ΝE	Fe	bruary 3,	2009		
	3	30. Name and address of pe		0			111 D	n C4	- D-!!	im -	MD 040	04	,			
		Theodore M. King				Examiner		in Stre	et, Balt	ımore,	MD 212	UT				
State Registra		31. Date filed (Month, Day, )		Z. Rec	gistrar's Signa	ature dear	and a									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2/14/2009 Celeste S. Barnes 2:15 PM M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol1 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 M 2 XF Days Hours 212-40-8037 87 8/22/1921 MS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1537 W. Liberty Rd. 21784 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Springfield State Hospita 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Henry Shoemaker Lillie Mae Read 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Hall/Daughter 810 Stiles Ct., Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Taylorsville UMC Cemetery 2/17/09 4 Donation 5 Other (Specify) Taylorsville, MD 21. Signature of Funeral Service License <sup>2</sup>Burrier ሳላ ያያያያ ያመታቸው ቸuneral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Approximate interval Between Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 mont Month Day Year 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 1 Tyes 25. Was case referred to medical

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be ဥ MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, The Medical Evaluation and angered.

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical

ð

Completed

Medical

State

Registrar

examiner'

27. Manner of Death

Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Yes 2 No

burial-trar attending physician for use as the buria nse ed by the signed by Be Certification: To

been has

To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica

Division of Vital Records, P.O. Box 68760,

requires that the death certificate be

5 Pending

investigation

determined

6 ☐ Could not be

2 No 26. Place of Death (Check only one)

Luntur My 2457

AOC	Other:	□ Nuroina H		. □ Desidence	<b>⇔</b> □ <b>1</b> 000	V		I A
		L Nursing H	ome	5 Residence	60 Clother	(Specify)	3006	Lete
28c.	Injury at Work?			Describe how inju				
	1 □ Yes	2 □No						

figation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

276-09

Certifying Physician: To the best of my knowledge, death opcurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier

5700

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

32 Registrar's Sign

durch Alexander Box eusli

31. Date filed (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

MEND TTEM#20b BerFH G888 2/17/09 WS tate of Maryland Debartment of Health and Mental Hygiene 2 23e, per MD g889 trificale of Death Reg. No. For State Registral Amend PII & Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year GOTUAN 14th 2009 **Physician BORTZ** 7:07 AM RITA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PIKESVILLE BALTIMORE 725 MT. WILSON LANE, #507 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🕱 F Yrs. 83 10/04/1925 OH 299-16-9144 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shovevent, the Wedical Examiner must be notified at 1 ☐Yes 2 No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE, #507 21208 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SCHOOL PSYCHOLOGIST EDUCATION 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GRADSKY BESS MAX SELTZER မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 Is
any Injury or other trau 725 MT. WILSON LANE, #507, ABE BORTZ / HUSBAND PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 2009 02/16/<del>2008</del> 1 Durial 2 Cremation 3 Removal from State BALTIMORE HEBREW REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Matt Cou 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ATHEROSCLEROTIC ITEMIT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi be execute Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached fr 1 □Yes 2 □ No 9 I Inknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ Yes 2 No 3 Probably 4 ₩ Chronic obstructive pulmonary disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 No spital or Attending Physician: Theory after death.
neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🖫 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled TM Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H45931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avonue Baltimore MD 21209 2835 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month FEBRUARY 12 2009 1. Decedent's Name (First, Middle, Las

3:30 P M

Physician /Medical

For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,4

	4	la. Facility Name (If not institution, give street and number)  NORTH OAKS HEALTH CENTER	4b. City, Town, or Location of Death PIKESVILLE	4c. County of Death BALTIMORE		
	L	5. Social Security Number 215-01-7377 6. Sex 1 № 2□ F 7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Bi   Months   Days   Hours   Min.   05/24/	rth ay, Year) 9. Birthplace (State or Country) MD		
1	$\vdash$	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City		
힏	'	MD BALTIMORE BALTI		1 □Yes		
Funeral Director	1	10e. Street and Number 725 MT. WILSON LANE, #434	10f. Zip Code 21208	10g. Citizen of What Country?		
by Funer	1	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	Was Decedent of Hispanic Origin? (Specify Yes or No Mas Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: WHITE		
ed b	-	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry		
To Be Completed by Funeral Director	F	(Specify only highest grade completed) (Give life. I	kind of work done during most of working DO NOT use retired) ENGINEER	AEROSPACE		
To Be C	1	17. Father's Name (First, Middle, Last) HARRY I. BASS	18. Mother's Name (First, Middle FRANCES	e, Maiden Surname) BERG		
	11		ng Address (Street and Number or Rural Route Numb GREENBERRY ROAD BALTIMO	per, City or Town, State, Zip Code) ORE, MD 21209		
	2		sition (Name of Date matory or other place) HEBREW CONG 02/15/2009	20c. Location - City or Town, State REISTERSTOWN, MD		
	1	21. Signature of Funeral Service Licensee	2. Name and Address of Facility SOL LEV 8900 REISTERSTOWN ROAD	INSON & BROS., INC. - PIKESVILLE, MD 21		
ical Examiner	1.3	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
Physician/Medical		23d. Date of delivery Month Day Y				
þ	F	Part II. Other significant conditions contributing to death but not resulting in the un	_	23e. Did tobacco use contribute to the cause of dea		
Completed			24a. Was auto perf 1	s an 24b. Were autopsy findings a		
Be	12	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only	one)		
tion: To	2	27. Manner of Death 1 Datural 5 Pending (Month, Day, Year) 28b. Time of Injury	1 3 DOA 4 A Rursing Home 5 Res	idence 6 Other (Specify) how injury occurred		
Certification:		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, str	eet, factory, office 28f. Location	(Street and Number or Rural Route Numb wn, State)		
1 1		29a. Certifier (Check only one)  1 Pertifying Physician: To the best of my knowledge, deatly and manner stated.	h occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(s)		
dic		29b. Signature and title of certifier	29c. License number	20d Data signed (Month Day Vens)		
Medical	1	I land the little of the littl	DIS872	29d, Date signed (Month, Day, Year)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 00 SOO, /Medical 4a. Facility Name (If not institution, give street and number) City, Town, of Location of Death Examiner 4c. County of Da 8. Date of Birth (Month, Day, ) Security Number Under 24 Hrs **Funeral** t birthday If Under 9. Birthplace (State or Foreign -0860 86 Months Hours Min. 1 M 2 Days Mary Yrs. Director rand Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Modical Error in with the notified at outce. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Mary by Funeral Director 1 ≥Yes 2 No 10e. Street and Number Ap 1. 101) 10f. Zip Code 10g. Citizen of What Count . Was Decedent Ever in U.S Armed Forces? 1 Yes 2 Wo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 100 3 ₩Vidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Norker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AMOS Duncan Dawson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Num City or Town, State, Zip Cod 20a. Method of Disposition 20b. Place of Disposition Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State routus Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solvice License. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one complicate shock and the shock of the that caused the death. Do not enter the mode of dying, Immediate Cause (Final Physician disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-traneal physician and the burial-transil Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month 5 Other (specify) Day Year 9 Unknown 9 Unknown II. Of er significant conditions contributing to death but not real lting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Hospital Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) -200 31. Date filed (Month, Day, Year) State 32

DHMH 17 Rev 1/2001

Registrar

Illiam Connoi		redistrai	tment of ificate of	Health a Death	nd Mental I		Reg. No. 20(	09 0445		
Physic ledical Exam		-				Date of De     Month	ath Day Year 15, 2009	3. Time of Death		
		William Lawrence Connors  4a. Facility Name (if not institution, give street and number)	4	b. City, Town,	or Location of Dea		15, 2009 4c. County of Dea	1900 hrs		
		2583 Running Wolf Trail		Odenton		1.23	Anne Arund			
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 216–66–4025 1XM 2F 53	t birthday) Yrs.	If Under 1 Your Months   Da	ear If Under 24H ays Hours M		irth(MM/DD/YYYY) 9. E ry 28,1956	Birthplace (State or Foreigr Country) Maryland		
any .		Usual Residence of Decedent           10a. State         10b. County         10c. City, To	own or Location	n				10d. Inside City Limits		
nd show :	_	Md. Anne Arundel	Odento	m				1 Yes 2X No		
daryland 28a-f show any 1 at once.	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co			
vith the N s 23a or	eral Dir	2583 Running Wolf Trail  11. Marital Status   12. Was Decedent Ever in U.S.	140.14	2111			USA			
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: friem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funer	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes	s, specify Cub	lispanic Origin? ( : an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 14. Race - Ame White, etc.	erican Indian, Black,		
rs afte ural", uine	<u>۾</u>	Widowed 4 X Divorced or Dates:		Yes 2 X N			Specify:	White		
2 hou "nat	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during mos	s Usual Occup st of working li	ation (Give kind or fe. DO NOT use re	f work done etired)	16b. Kind of Busines:	s/Industry		
D36 thin 7 ne. than	ם	12 4	Defens	o Comt	*****		CATO			
5-0 led wi tygien other	S	17. Father's Name (First, Middle, Last)	Derens	e cont		ne (First, Middle,	SAIC Maiden Surname)			
121 I be fi ental I urked	Be	Martin L. Connors, Sr.					McGarry			
O 2, should nd Ma is ma	ပ	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing A	Address (Str	eet and Number or	Rural Route Nu	mber, City or Town, Sta	te, Zip Code)		
nd 2 salth a		Martin L.Connors, Jr.	2150	Mardic	Drive 1	Forest H	iill, Md. 2	1050		
Ore ges I a of He If ite		200.116	ce of Dispositi matory or othe	on (Name of c r place)	emetery,	Date	20c. Location - City of	or Town, State		
tim tipent trant:		4 Donation 5 Other Specify: Bayv			2/2	28/2009	Baltimore	City MD		
Bali permit Depar Impon		21. Synature of Experal Service Licenses		me and Addre	ss of Facility	Schimune	k Funeral 1	Home		
Physician	_	238. Part Letter the disease, or complications that caused the death. Do	9	705 Be	lair Rd.	Notting	ham, Md. 2			
/Medical		laliure. List only one cause on each line.			g, such as cardiac	or respiratory an	est, shock, or heart	Approximate Interval Between Onset and		
xaminer		Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovas Due to (or as a consequence of):	cular Disea	ase				Death.		
		Sequentially list conditions, b								
	Examiner	if any, leading to immediate Due to (or as a consequence of):			7-1111					
	am	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
cuted ind transi		d.								
60, ate be executed hysician and e burial - transit	Physician/Medical	UNPENDED   X AMENDED   20c per FH g888 2/17/09 TT   20b, perFH G888 2/27/09 TT								
760 icate l	/We	IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of deliver								
certif	lä.	past 12 months?	1 Live birth 2 Fetal death 3 Ectopic pregna					Day Year		
Box death	ysi	1 Yes 2 No 9 Unknown g Unknown	5 Other	(Specify)						
ires that the death certificat signed by the attending ph to detached for use as the		Part II. Other significant conditions contributing to death but not result	Iting in the und	erlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?		
ires th	d by	Chronic Alcoholism	,				2 No 3 Pro			
cords, law requir has been s	Completed					24a. Was		utopsy findings available		
ecc he lav ite has	Ĕ						med? death?	completion of cause of		
Vital Recysician: The his certificate director, page		25. Was case referred to medical	-	26 Plac	e of Death (Check	1 Yes	2 No 1 Y	es 2 No		
Vita	o Be	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER	/Outpatient 3		Othor		Residence 6 ✔ Othe	r: Scana		
n of ing Pt	Ë	27. Manner of Death 28a. Date of Injury 28t	b. Time of Inju	ry 28c. Inju	iry at Work?		now injury occurred	1. Ocene		
ion teath tor:	읉	1  ✓ Natural 5 Pending 2 Accident Investigation (Month, Day, Year)		1	Yes 2 No					
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death  Fineral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	3 Suicide 6 Could not be determined	, farm, street, f	actory, office t	ouilding, etc.	28f. Location (S or Town, S	Street and Number or Ri	ural Route Number, City		
To the Hospit within 24 hour To the Funers completely fill		29a. Certifier (Check only)  Certifying Physician: To the best of my knowledge, d	death occurred	at the time, d	ate and place, and	due to the caus	e(s) and manner as stat	ed.		
To the within To the Comple	Medical	2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation	, in my opinior	n, death occurred a	at the time, date	and place, and due to th	e cause(s)		
	≥	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)		
		Chler		O.C.	M.E.		February 16, 200	9		
12		30. Name and address of person who completed cause of death (Item 23a	,	1						
8			Penn Stre	et, Baltimo	ore, MD 21201	1				
Sta Registi		31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	- /	. ,						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 5:45P 14.2009 <u>Peter N. Courtalis</u> February /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Balto. Parkville 10139 Fontaine Drive Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 74 yrs If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days Hours 1 X M 2 □ F December 22,1934 Greece 214-44-9040 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Directo Balto. Parkville Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 10139 Fontaine Drive 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No Specify. White Specify: <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Food Service</u> <u>Business Owner</u> 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Courtalis Eugenia Anthakos ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10139 Fontaine Drive Parkville, Md.21234 Despina Courtalis Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-18-2009 Parkville St. Demetrios 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 100 Immediate Cause (Final month disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 No 1 ☐ Inpatient Certification: To

Physician /Medical Examiner

**Funeral** 

**Director** 

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ir e Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Examine physician and s the burlal-trans Physician/Medical attending ph ed by the detached 1 s been signed b à Completed page 2 funeral director, Be

law requires that the death certificate be executed

Jas

certificate I Physician:

this

After t

within 24 hours after usaw...

To the Funeral Director: Af

ospital or Attending I

Box 68760.

P.O.

Division of Vital Records,

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manne Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

BALTIMORE, MD 21237

09

MD eman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 FRANKLIN SOUAREDRIVE UMAN 910

State Registrar

Medical

29b. Signature and title of certifier

(Check only

within 24 hours after death.

		Pleas	se Type or Prin				. Ensure A Health and N	•	_	le.	
		1 - State Registrar			Ce	rtificate of	Death		Reg. No. 20	09	04457
Physici	an	1. Decedent's Name (First, Middle						2. Date of De Month	Dav	Year	3. Time of Death
/Media		Norma Jean C				T		Februai	ry 16, 20		1:15 A M
Examir	ner	4a. Facility Name (If not institution, 14:103 South  5. Social Security Number 520–30–5800	Springfield	Road e (In yrs. la	a <i>st birthd</i> ay) 77 Yrs.	st birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Months Days Hours Min, (Month, Day, Year)					orge 's large (State or Foreign fry) noma
Director		Usual Residence of Decedent			7 7			July 19	, 1931	OKIA	Homa
rylanc how	_	10a. State 10b. County		1.0c. City,	, Town or Lo	ocation				10	Od. Inside City Limits
Ba-f s	Director		e George's	Br	andyw						1 ☐ Yes 2 ☐XNo
a or 2	Dir	10e. Street and Number	field Doo	J		10f. Zip Code	613	10g. Citizen of What Co			.ry?
leath	Funeral	14103 South Spri	12. Was Decedent	Ever in U.S	. 13.						an Indian.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if we fludical Examinar must be notified at once.	Completed by Fun	1 ☐ Never Married 2 ☐ Marrie 3 🕅 Widowed 4 ☐ Divorced	Armed Forces,?	No	l l	If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black Specify:	Black, White, etc.  Specify: White	
72 h		15. Decedent's (Specify only highest	s Education t grade completed)		16a. Dece (Give	dent's Usual Occup	sual Occupation 16 vork done during most of working use retired)			iness/Ind	ustry
within ene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5	i+)		<i>bo not use retired</i> nemaker	d)		Own Ho	me	
filed Hygi other ent, t	BeC	17. Father's Name (First, Middle, L	ast)		18. Mother's Name (First, Middle, Maiden Surname)						
Jenta Jenta rked tic ev	PB 0	Bryan Bilyeu					Edith	Porter			
2 shore and 1 is ma auma		19a. Informant's Name/Relationsh	ip (Type. Print)				and Number or Run		-	•	
and health m 27		Kathleen Smith	, Daughter	Tool Di			pringfiel			•	
nt of h		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation	3 ☐ Removal from State			osition (Name of matory or other place		Date	20c. Location - C		
artme artme ortant injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		Meti		<del></del>	nc.   02/1		Baltimor		
permi Depa impo any ir once		Thomas Grego	r			cremation 299 Frede	sssociety rick Road	Baltin	nore, Mar	c y <b>i</b> an	d 2 <b>122</b> 8
Physician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)		20	SCLE	ter the mode of dyin	ng, such as cardiac	or respiratory a	rrest, UUDR 17	158	Approximate Interval Between Priset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b								
the death certifi by the attending I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months?  1							of deliver	y Day Year
quires that en signed I uld be det	þ	Part II. Other significant condition	ns contributing to death be	ut <b>n</b> ot result	ting in the u	nderlying cause give	en in Part I.		obacco use contrib ⁄es 2 □ No 3	ute to the	
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ysicia s cert directo	To Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2∏E	R/Outpatier	nt 3 DOA Othe	26. Place of Death		<i>ne)</i> dence 6 □Other	(Specify)	
ath. ath. r: After thi	ation: T	27. Manner of Death  1 Matural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da	ry 2	28b. Time of Injury	f 28c. Injury Work			now injury occurred		
tal or Atters as all Directors led in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin				eet, factory, office		28f. Location <i>(S</i> <i>City</i> or Тои	Street and Number vn, State)	or Rural	Route Number,
the Hosp nin 24 hou the Funer npletely fil	Medical	(Check only 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	f examination	ledge, deatl on and/or in	vestigation, in my o	pinion, death occurr	and due to the ed at the time,	cause(s) and mand date and place, an	ner as sta d due to t	ited. :he cause(s)
Ç 3 ∰ Ç	2	29b. Signature and title of certifier				29c. License	e number	-	29d. Date signed (	Month, D	ay, Year)
10	}	30. Name and arrange of account	the completed serves of the	ooth /lt 1	22a) /Tima	Print)	107 17	/	COIVAL	4 (	1, acy
Sta	to-	30. Name and address of person w	I MD.	170	70 C	DED LIKE	CENTER	WH	CACKF N	Id.	20602
Registr		FFR 1 7	2009 Diser	a f	9. A.	arkel					

State of Marvland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 19:04 **Physician** CLOUD 14 FEBRUARY 2009 JANELLE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number Days Funeral PA 201-40-2790 7-20-1949 59 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show aţ 1 XYes 2 No 3a or 28a-f sl Director PA Dauphin HERSHEY 10g. Citizen of What Country? 10f Zip-Code 10e. Street and Number 17033 USA 124 Brookside Avenue 23a Funeral death v must Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or items 2 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Yes Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Baltimore, Maryland 21215-0036 Specify: by 3 Widowed 4 Divorced White Year or Dates 'natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Completed 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Profession Care Coordinator Insurance N/A 12th grade 17. Father's Name (First, Middle, Last) other 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental H 27 Is marked of traumatic ever Geraldine Clark Harry Foutz ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hersey, PA 17033 item 27 l 124 Brookside Avenue B. Cloud-Husband Harry other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State = 5 2-20-2009 Lebanon County, PA Gravel Hill Department Important: I any injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 1) la ano 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Cryptogenic Ci ue to (ras a consequence of): 3 months **Physician** circhosis disease or condition resulting in death) /Medical Examiner week Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician an Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tyes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Tyes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Yes 2 X No 2 ER/Outpatient ၉ 24 hours after death. • Funeral Director: After this 28a. Date of Injury (Month, Day Year) . Injury at Work? 28d. Describe how injury occurred 28b. Time of 28c. 27. Manner of Death Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, þ 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completely fi (check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ρ MEDICAL DOCTOR RES-000 FEBRUARY 2009 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 HOPKINS HOSPITAL AMY PARKER RUHL JOHNS 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State FFR 17 2009 Registrar

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			For State Registrar			ertificate of			Reg. No 2 0 0 9	04459		
	Physici	an	1. Decedent's Name (First, Middle, L	,				2. Date of Dea Month	th Day Year	3. Time of Death		
Ans.	/Medi	al	Shirle: 4a. Facility Name (If not institution, g	y B. Chri		4h City Town o	r Location of Death	Feb.	14, 200 4c. County of Dea			
-	Examir	er	Stella Maris		, 		onium			timore		
	Funeral		Social Security Number     6.		ge (In yrs. last birthday Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y Year) 9. Big	thplace (State or Foreign ountry)		
	Director		033–20–5821 Usual Residence of Decedent		82 YIS.			July 25,	1926 Mar	sachusetts		
	arylan show	<u>_</u>	10a. State 10b. County		10c. City, Town or L		185.			10d. Inside City Limits  1文 Yes 2 □ No		
	the M 28a-f	Director	MD  10e. Street and Number			Baltim 10f. Zip Code	are	1	l 0g. Citizen of What C			
	h with	Funeral Di	4013 White Avenue,	Apt. B3		2120	06		United Sta			
	items		11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H		pecify Yes or No- o Rican, etc.)		erican Indian,		
)30 Ir, o	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ☐ If Yes, Give X Year or Dates:	No	1 □Yes 2 No	Specify:		Specify:	White			
2-0	72 hou	eted	15. Decedent's (Specify only highest g	Education trade completed)	16a. Dece	16a. Decedent's Usual Occupation		kina	16b. Kind of Business	,		
21215-0036	within iene. <b>than</b> "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired	*		Baltimore Co School Syst	-		
<u>م</u> 2	be filed within tal Hygiene. Id other than event, the file	Be C	17. Father's Name (First, Middle, Las	st)		III WAR		ne (First, Middle, i	Maiden Surname)	3.1		
ylaı	2 should be and Menta is marked is raumatic ev	일	Harold Marning					aret E. Se				
Maryland  od 2 should be file th and Mental Hy 27 is marked oth	id 2 sh Ith and 27 is m 'traum		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zij  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zij  2903 Orsburn Lane, Joppa, Maryland 21085									
ore,	ges 1 and 2 should to f Health and Mer If item 27 is marke or other traumatic		Linda Kacpura - Dau 20a. Method of Disposition	-	20b. Place of Disp			_	20c. Location - City or	Town, State		
altimore,	Page tment tant: If jury o		1 ☐ Burial 2 ▼ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Evans Fure	ral Charel & Svrs.—Helair	Feb.	17, 2009	Forest Hill,	Maryland		
Baj	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Evans Funeral Chapel & Cremation Services - Parkvi  8800 Harford Road, Parkville, Maryland 21234									
			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	mplications that caused vione cause on each li	d the death. Do not er					Approximate Interval Between		
S.,	Physician		Immediate Cause (Final disease or condition resulting in death)		OBSTRUCTI	VE PULMON	ARY DISEA	SE		Onset and Death		
-	/Medical Examiner	Due to (or as a consequence of):										
	P #	iner	Sequentially list conditions, from Julian Cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):							
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09289	te be e ysician e buria	calE		d	, ,							
99	eath certificate be e attending physician for use as the buria	Physician/Medical	IF FEMALE:									
Вох	attend for us	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3		23d. Date of de Month	livery Day Year				
P.O.	that the died by the detached	hysi	1 ☐ Yes 2 <b>X</b> No 9 ☐ Unknown	9 ☐ Unknown		Other (specify)						
S,	es be be	b	Part II. Other significant conditions	contributing to death b	out not resulting in the u	underlying cause give	en in Part I.		bacco use contribute to			
202	law requii as been s 2 should	eted						24a. Was a		robably 4X Unknown		
Be	The law te has age 2 s	Completed	<u></u>					autops perforr	by prior to death?	utopsy findings available completion of cause of		
ta	clan: Tertifica ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deal			s 2 □No		
Division of Vital Records,	Attending Physician: The sr death.  vector: After this certificate h. by the funeral director, page		1 ☐ Yes 2 🗶 No 27. Manner of Death	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie		4 Li Nursing H		ence 6 X Other (Spe ow injury occurred	ecify) HOSPICE		
on	nding ath. r: After e fune	Certification: To	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ny, Year) Injury	Worl	Yes 2 □ No	Zou, Describe no	ow injury occurred			
N N	or Attener after death Director:	tifica	3 ☐ Suicide 6 ☐ Could not determine	A 26e. Place of in	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,		
			29a. Certifier 1 ☐ Certifying F	Physician: To the heet	of my knowledge, dea	th occurred at the tir	me date and place	and due to the o	ausp(s) and manner	s stated		
	To the Hospita within 24 hours To the Funeral completely filled	Medical		aminer: On the basis of	of examination and/or in							
	To the within 7	Ĭ	29b. Signature and title of certifier		-6110	29c. Licens	e number	2	9d. Date signed (Mont			
		-	Jennifles	Hauf C	AVY	K15	1624		2/16/20	XX		
1			30. Name and address of person who	completed cause of c	teath (Item 23a) (Type,	Print)						

State Registrar JENNIFER HAUF, CRNP
31. Date filed (Month, Day, Year)
FEB 17 2009

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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and the second	1- For State Certificate of Death Reg. No.								, , , , , ,						
Physici		1 Decedent's Name (First, Middle, Last) 2. Date of Death									Year		. Time of Death		
Medical Exami	ragabe breeze croacier									1942 hrs					
<i>(</i> )		4a. Facility Name (if not institute University Hospital	on, give s					b. City, Town, or Baltimore	. City, Town, or Location of Death Baltimore			4c. County			
Funeral		5. Social Security Number	6. Sex	. Sex 7. Age (In yrs. la			<u> </u>	If Under 1 Year	ir If Unde	er 24Hrs.	8. Date of Bi	rth (MM	-	9. Birthr	place (State or
Director		216-43-8518	1.X M	2 F	14		Vrs	Months Days	Hours	Min.	1/30/	100	5	Foreign Coun	try) Maryland
		216–43–8518   1X M 2 F   14   Yrs.   Months Days Hours Min								1/30/1995   Country Marylan					
any		10a. State 10b. County			10c. City,	Town or Lo	catio	on					- "	1	0d. Inside City Limits
* .	_	MD n/a Baltimore												1 X Yes 2 No	
Maryland 28a-f show 1 at once.	읈	10e. Street and Number						10f. Zip Code			1	10g. Citizen of What Country?			y?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Director	2709 Wilkens Avenue						21223				τ	JSA		
h with	Funeral							Decedent of His			)-	14. Race White		n Indian, Black,	
r deat or ite	필	1 Yes 2 X No													
s afte ral",	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates:										Specify:		hite	
5-0036 ed within 72 hours tygiene. other than "natur															
36 in 72 han ticat	ompleted	Blementary/Secondary (0-12)					Student					9	chool		
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115.	To Be C	Albert George	. ,	•					Mary Adele Cl			. ,			
S de de		4										(ip Code)			
and sho		Mary Adele Cloutier / Mother   2709 Wilkens Avenue, Baltimore, Maryland 21229													
e, M 1 and 2 Health Titem 2		20a. Method of Disposition				Place of Dis	posit	tion (Name of cer			Date		Location -		
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti		1 Burial 2 X Crematio		Removal fr	OIII Otate	crematory or				2/20	/2000	D <sub>2</sub>	1+ima	150	Mana I and
o ta me	-	Donation 5 Other Specify: Bayview Crematory 2/20/2009 Baltimore, M 2 Signature of Funeral Service Ricensee 22. Name and Address of Facility Hubbard Funeral Home,										Maryland			
Balt permit. Depart Impor injury		R. Lad C	Some	Q			41 (	07 Wilke	ng A	nul	Daru r Ralt	une imo	rai n	ione,	INC.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval													
/Medical		failure. List only one cause on each line.  Between Onset and Death Death													
xaminer		Immediate Cause (Final disease a. Complications of Astrima a. Complications of Astrima bue to (or as a consequence of):													
		Sequentially list conditions,  b													
	ner	if any, leading to immediate cause. Enter Underlying Cause													
	Examiner	(Disease or injury that initiated events resulting in death) Last	e to (or as a	o (or as a consequence of):											
executed an and al - transit		evente resolung in quality East	d												
- 60 15.15	n/Medical	UNPENDED		AMENDED											
68760, certificate be nding physicise as the buri	Me	IF FEMALE:		23c. If yes,	outcome of preg	nancy						23	d. Date of	delivery	
· · · · · · · · · · · · · · · · ·	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectop							Ectopic	c pregnan	су		Month ·	Da	y Year
Box 68 e death cert the attendin	sic	1 Yes 2 No 9 Unknown 9 Unknown													
that the death cened by the attend detached for use	Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?													
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	Ş							, , ,			1 Ye	s 2	<b>/</b> No 3	Probal	oly 4 Unknown
of Vital Records, P g Physician: The law requires t after this certificate has been sign neral director, page 2 should be c	Completed										24a. Was	an	24b. W	Vere auto	psy findings available
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tal Re(	ၟ											2 🗸	No 1	Yes	2 No
tal ictan: certi	Be	25. Was case referred to medica examiner?		pital:					of Death Other	(Check or	-				· · · - · -
f Vi Physi er this	은	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other:													
n of diug Pl h. : After : funera	ä	1 Natural 5 Pen	dina	28a. Date (Month	, Day,Year)	200. Hine	OI III	· ·	es 2		ou. Describe	now m	july occurre	eu	
ivision or Attent after death Director:	cati	o ren	stigation	00 - 51				1			201.4	0			
Division of Vital Rec Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate tely filled in by the funeral director, page	Certification;	dete	ld not be rmined		e of Injury - At h	ome, rarm, s	treet	t, factory, office b	uilding, et	c.   2	or Town,		and Numbe	r or Rura	I Route Number, City
ospits hours nuera		4 Homicide		(Specify)						- 11		-		_	
To the Hospital within 24 hours. To the Funeral	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)													
To To		and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Date signed)													
A.		(0 11) ~~						O.C.M.E.				February 15, 2009			
<b>U</b> M		20 Name and address of active	who ===	anloted	on of don't (live-	13321							, 1	, ===0	
		<ol> <li>Name and address of person</li> <li>Donna M. Vincenti, M</li> </ol>			se or death (Item Nedical Exam	,	11	Penn Street,	Baltime	ore. MD	21201				
2	ate	31. Date filed (Month, Day, Year)			sistenda Cienati		_								
Regis		FFR 1 7 2	009	120	wa B	ba	in								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009° Month **Physician** COLEMAN HATTILE /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BACTIMIRE OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min. Country) 1 □ M 2 🖫 🗲 -718 Carolina Director North Usual Residence of Decedent t and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural". or المصمد 279 مد مصر مصر في المساورة 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Funeral Director Baltimore 1 DYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA endal 2120 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Newer Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Black Specify Completed by 3 Widowed 4 □ Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ines Mar ဥ benjamin other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 (a oi tol Heights Item 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p ₽ <del>1</del> ō 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Department of Important: If any injury or once. Tarboro Cemetry Feb 21, 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howell Funeral 21. Signature of Funeral Service Licensee Home 4600 hi berty Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardix or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEDUMINAL AURTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner ri any, leauling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Box 68760, the burial-tran Due to (or as a consequence of): attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ZTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 □ No 1 ∐ Yes 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 | Pendina 1 ☐ Yes 2 ☐ No investigation death. hours after death uneral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours
the Funeral Directory filled in by 4 Homicide the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

ADRIGANA

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

within 2

Baltimore, Maryland 21215-0036

P.O. |

Records.

Division of Vital

GREENE

29c. License number

ST. BALTIMORE MD 21201

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04462 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** EUNICE. 2.30 PM February 2009 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ELLICOLE HEALTH + REHAB CHI HOW ARD Under 1 Year If Under Ionths Days Hours 24 Hrs. 8. Date of Birth Min. (Month, Day, 9. Birthplace (State or Foreign Country)
NOR EM 1(0R0) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Z15-78-4697 Usual Residence of Decedent March 14; Director 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examinar roust be notified at HOWARD Director 1⊠Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KENSINGTOW "natural", or items 23a or 2500 U5 Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 Specify: ASIAN 1 ☐ Yes 2 No <u>م</u> Specify 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' any Injury or other traumatic event, The The O.Co. Elementary/Secondary (0-12) College (1-4or 5+) HOME M 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HEE HWANG KIM ပ MOON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (HUSDH ND 2500 KENSINGTON GUNS UNIT ELLICOTT CITY MAZICUE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-17-09 CREMATORY METRO BALTIMORE, MID 22. Name and Address of Facility HowEll 21. Signature of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications in saused the death. Do not enter the mode of dying, such as cardiac or rest fratory arrest, shock, or heart failure. List only one cause on each line. 20190 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BILATERAL PNEUMONIA weak /Medical Due to (or as a consequence of) Examiner CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician; The law requires that the death certificate be executed Breast CARCINOMA Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 🗹 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director; After this 28a. Date of Injury (Month, Day, Year) the funeral 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 Accident investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 30469 February 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.B. VEUANK 8850, COLUMBIA 100 BARKWAY & 308, Columbia. MD. 21045 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore

29c. License number

K146251

29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, within 24 hours e

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

7 2009

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Avenue

32. Registrar's Sgnature

		For State of N  1 - State Registrar	laryland / Dep <i>Ce</i>	artment of F ertificate of			giene Reg. No 2009	04464				
		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death							
Physici /Medi		Michael Jay Cooper				Februa	ry 14, 200					
Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of De										
		Stella Maris	nium		Baltimo							
Funeral		47714 0	Age (In yrs. last birthday Yrs.	If Under 1 Year   Months   Days	If Under 24 Hr Hours Mir	S. B. Date of Birt (Month, Da	h 9. Bi	rthplace (State or Foreign Country)				
Director		103-34-6937	Sept.6,	, 1944 New York								
land Dw	Director	Usual Residence of Decedent  10a. State										
Mary f she		Maryland Baltimore Towson 1 □ Yes 2√ No										
r 28a		10e. Street and Number	10f. Zip Code				10g. Citizen of What C	Country?				
3a o	<u>=</u>	512 Locksley Road		2120	4		USA					
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ont, the Medical Evantine must be notified at	Funeral	11. Marital Status 12. Was Deceder Armed Forces	nt Ever in U.S. 13.	Was Decedent of H	dispanic Origin?	(Specify Yes or No-	14. Race - Am Black, Wh					
after after	J.F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐	χNο	1 □Yes 2 v No	Specify:	nto mount oto.	Specify:					
OO.	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates			White							
15- n 72 "nat	Sete	15. Decedent's Education (Specify only highest grade completed)	orking	16b. Kind of Busines	s/Industry							
within liene.	To Be Completed	Elementary/Secondary (0-12) College (1-40)		Law								
filed I Hyg other		17. Father's Name (First, Middle, Last)	ame (First, Middle,	e (First, Middle, Maiden Surname)								
arylance should be f and Mental I s marked of numatic eve		Harry Cooper	ne We	e Weinstock								
lar)		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street	and Number or I	Rural Route Numbe	er, City or Town, State,	Zip Code)				
and and and and and and and and and and		Suzanne Cooper / Wife		Locksley		Cowson, M	1. 21204					
Ore jes 1 rof H if iter		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from Stat	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City o	r Town, State				
Limor Pages tment of tant: If its jury or o		4 □ Donation 5 □ Other (Specify)	Hilltop	Service C		17/09	Towson, Mo	1				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantmer must be notified at once.		21. Signature of Fune at Service Ligensee		22. Name and Addre		al Home. :	1050 Yo	ork Road				
		23a. Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										
Physician		shock, or heart failure. List only one coalse on each line.  Immediate Cause (Final disease or condition  PULMONARY EOSINOPHILIA  Interval Between Onset and Death										
/Medical	Н	resulting in death)	as a consequence of):									
Examiner	_	Sequentially list conditions. b.										
ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):									
y secu	edical Examiner	that initiated events c.	us a consequence of):									
68760, & ificate be executed g physician and as the burial-transit												
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Records, P.O. Box 6	Completed by Physician/M	IF FEMALE: 23c. If yes, outcom		☐ Ectopic pregnand		23d. Date of delivery  Month Day Year						
O. B the deat the att		1 Yes 2 No 4 Pregnant		Month Day								
<b>15, P.O.</b> res that the de signed by the a be detached f		9 Li Unknown	00- 8:44	220 Did tobacco use contribute to the square of deeth?								
res the signer be d		Part II. Other significant conditions contributing to death		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown								
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Rec le law has l						24a, Was autop	sv prior to	autopsy findings available completion of cause of				
n: Th		Of Management and display					2 <b>X</b> No 1 □ Ye	s 2 No				
Vii s cert	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa	utient 2 ER/Outpatie	ont 2 DOA Oth		eath (Check only o		ecify) HOSPICE				
Division of Vital Records, or attending Physician: The law requires the after cleath.  Director: After this certificate has been signed in by the funeral director, page 2 should be done.	n:T	27. Manner of Death 28a. Date of Ir	njury 28b. Time	of 28c. Inju	ry at		now injury occurred	ecity) HOST FOL				
ior arth. rr: Aff	Medical Certification: To	1 X Natural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No										
Division  I or Attending after death. Director: After		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building,	njury - At home, farm, st etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
ospital o hours aft uneral Di												
王 4 正 5		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
To the within 2 To the comple		29b. Signature and title of certifier	29d. Date signed (Mor	I. Date signed (Month, Day, Year)								
F > F 0		I Semule theut	CONP	VIE	7629		2/16/2					
5		30. Name and address of person who completed cause of	f death (Item 23a) (Type		1441		V(1/0/0					
		JENNIFER HAUF, CRNP 2300	DULANEY V	ALLEY RD.	TIMONI	UM, MD 2	1093					
	ate	31. Date filed (Month, Day, Year) 32. Regis	strar's Signature									
Regist	rar	EER 172009 Beneur	ft. Harris									

7:58 а.ш.

FEBRUARY 14, 2009

MICHAEL COOPER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EBPUATY 2.00 K August Anthony Cortina 13 2009 /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE ANNE BALTIMORE WARHINGTON MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1**X** M 2 □ F Months Days Hours Director 219-18-3238 April 22,1926 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ... any injury or other traumatic events. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County 1 Yes 2 No Director Maryland Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 United States 104 Grason Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of the Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Electrical Technician Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Cortina Maria Rose Onorato ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Nomini Drive Arnold, Maryland 21012 Mr. Frank Wayne Cortina / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition

1X Purial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 2/17/2009 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01121 Services, 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEALMOND IT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MENTI Sequentially list conditions, the last good for the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for as a consequence of Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician sthe burial Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy performed this certificate Division of Vital 1 □ Yes 2 No 2 🗆 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation within 24 hours are: common to the Funeral Director Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🔲 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

10+1

State Registrar 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature

30. Name and address of person who

nue gleu Burnie mo 20161

pleted cause of death (Item 23a) (Type, Print)

**Physician** /Medical Examiner attending physician and for use as the burial-trans P.O. Box 68760, death certificate be signed by the at the detached for Division or Vital Records, should has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

page 2

**Physician** 

/Medical

Examiner

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Certification:

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29a. Certifier

IF FEMALE:

**Funeral** 

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

the Medical

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permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important; If item 27 is marked other any Injury or other traumatic event, II

within 72 hours after death

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D 46285

🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) February 9, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bone, M.D. 10905 Fort Washington Road, Fort Washington, MD 20744

State Registrar 31. Date filed (Month, Day,

32 Registrar's Signature 10 carre

parks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2/14/2009 **Physician** 11:06 AM Jack Graham Corvin, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice - Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 5/11/1933 1 X M 2 □ VA Director 226-40-2437 75 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a4 show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Expressions must be notified at Director 1 ☐ Yes 212 No Sykesville MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 248 W. Obrecht Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1953-55 1 ∐Yes 2 No Specify þ Specify: 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Horseman Horse Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Alice Kegley Raymond Corvin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If Item 27 is any injury or other trau <u>once</u>. 248 W. Obrecht Rd., Sykesville, MD 21784 Glenna Corvin/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donamn 5 ☐ Other (Specify) Lake View Memorial Park 2/19/2009 Sykesville, MD 21. Signature di Funeral Service Lie 22. Name and Address of Facility. Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. art 1. Enter the disease, or complications that shoc, or heart failure. List only one cause on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Im nedia\* Cause (F disease or condition res fling in death) nedia\* Cause (Final **Physician** any /Medical Due to (or as a consequence of): Examiner rola Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last ner The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical ast attending p IF FEMALE: 23c. If <u>ye</u>s, outcome of <u>pr</u>egnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a 1 □Yes 2 □ No. o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performed? certificate of Vital 1 ☐Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Danie (Specify Dove House 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled tire certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANSURIYA 349 malwim DR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 12, 16a per th 8888 2-20-09 vt. Amend Item 26 per Vers y 8889 652 117 405 of beauth and Mental Hygiene 1 - For A State Registrar 14468 Reg. N2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ) Day **Physician** ORREST CALHOUN 0200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** LNIW. OF MARYLAND MEDICAL CENTER N/A CTIMORE 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y)
Dec. 23, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1929 Days 1 ☑ M 2 ☐ F Months Hours Min Mary Land Dec. 214-26-8098 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at Catonsville 1 ☐Yes 2 No Funeral Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA ST 425 21228 717 Maiden Choice Ln. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Exercited 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Supering 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Superintendant Patuxtant Institution College (1-4or 5+) Elementary/Secondary (0-12) Associate Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) В. Kufer Calhoun, Sr. Margarete Forrest ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Maiden Choice Ln., ST 425, Catonsville, MD 21228 Elaine S. Calhoun (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/16/09 Baltimore, Maryland 4□Donation 5 DOther (Specify Entombment 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final COMPLICATION OF CERVICAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Medical Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed BY MEDICAL EXAMINER IFICATION APPROVEO attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ANKYLOSING SPONDYLITIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown PREVIOUS CENTRAL SPENE FRACTURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 110/09 Unknown 1 ☐ Yes 2 No 2 Accident filled in by the Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7/7 MATDEN CHOIL CANE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide HOME To the Hospital o within 24 hours af To the Funeral Di STE 425 BALTIMORE MD 21228 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEPHEN THOMPSON 22 MD GREENE ST BAUTIMORE MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FFR 17 2009 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney Reg. No. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Cannon 5:21 Elizabeth Mary EBRUARY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES PALTIMORE HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Months Days Hours 1 ☐ M 2 👿 F 1942 Maryland Oct. 18. Director 217-38-2054 66 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "McCral Event out it us be notified at 1 XYes 2 No Director Baltimore Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21230 2045 Grinnalds Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2√☐No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Market 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Worsham Agnes Peyton Joseph ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other trat Pages 1 and 2 George H. Cannon, Sr. (Husband) 2045 Grinnalds Avenue, Baltimore, MD 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department c Important: If any Injury or once. 2/14/09 Baltimore, Maryland Loudon Park Cemetery 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Li 3620 Wilkens Ave., Baltimore, MD 21229 23 art Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOUR CUTE MYOCARDIAL **Physician** NFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner vere EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner requires that the death certificate be executed ATHEROSCIEROSIS OFONARY and the burial-tra Due to (or as a consequence of) Hecords, P.O. Box 68760, physician use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Vear 5 Other (specify) 9 Unknown 9 Unknown þ as been signed I 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an Jas page P certificate LeF 2 🗓 No Vital ARCINOMA Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAINEN Choice LA M. MACHIEAR 720C BER 31. Date filed (Month) Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Februari Day Vear **Physician** Raymond Coleman 11:154 M /Medical 7009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Jan 2, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 1 M 2 □ F 1923 Maryland Director 86 215-14-7678 Usual Residence of Decedent show 10a State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at **Funeral Director** 1 ☐ Yes 2X No Pikesville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Slade Avenue Apt 115 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2K) Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced White "natural" WWII The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 C.P.A. Federal Government of Health and Mental Hygie fitem 27 is marked other in other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Coleman Mildred Coleman Arthur Murray ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other trauonce. Coleman 7 Slade Avenue Apt 115 Pikesville, MD Margaret 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 2/23/09 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 11824 Reisterstown Road 1. Wayne Osterline Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart gillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kespiratom /Medical Due to (or as a consequence of) Examiner Prisumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burlar-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death! Division of Vital Records, Be Completed by 1 ∏Yes 2 ∏No 3 Probably 4 ☑ Únknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 - No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 to ther (Specify 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 d Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morus Baltmone Volucian 2830 Sm 144 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

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**Physicia** /Medic Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Medical Examinar must be muithed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,—

> Sta Registrar

	Registrar				Cei	rtificate of	Deam		Reg. N	10.L U	UJ	0441	i
n	1. Decedent's Name	e (First, Middle, Las	st)		_	<del> </del>		2. Date of Do		Day	Year	3. Time of Death	
al		Calla						February	1	2 20	09	11:15 <sup>a<sub>M</sub></sup>	_
er			e street and number)			4b. City, Town, o		Death		lc. County			
-	Wilson He 5. Social Security N			e (In yrs. last b	oirthday)	Gaithe If Under 1 Year	If Under 24		rth	lontgo	g. Birth	place (State or Foreign	7
	267-28-34	164	<b>⊠</b> M 2□ F	81	Yrs.	Months Days	Hours I	Feb. 3	1°9	28	F10	rida	
	Usual Residence of			10- 0't T								40d Inside Oit I inside	_
<u> </u>	10a. State	10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
ect	Maryland  10e. Street and Nur	Montgon	nery	N	lorth	Potomac	:		100 (	Citizen of \	Mhat Car		_
			or Dudre			2087	0						
Completed by Funeral Director	11. Marital Status	ince Vall	12. Was Decedent	Ever in U.S.	13.1			1? (Specify Yes or N		ited		ican Indian,	_
Ē		ed 2 Married	Armed Forces?	Me				n? (Specify Yes or N Puerto Rican, etc.)		Blac	ck, White	, etc.	
ğ	3 🗆 Widowed	4 Divorced	If Yes, Give W Year or Dates:	WII/ Korea		1∐Yes 2⊠No	Specify:			Specify	, Whi	te	
etec	(Spec	15. Decedent's Ed	ducation		a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of	f working	Til.	Kind of B		•	
m d	Elementary/Seco	ndary (0-12)	College (1-4or 5	(i+)					1.	sonry		de	
္တိ	17. Father's Name	(First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	[01	. V11	Engineer		Name (First, Middle		ocia en Surnan			_
To Be	John Ca							eline Hig			,		
Ě	19a. Informant's Na	ame/Relationship (	Type. Print)	19	9b. Mailir	ng Address (Street		or Rural Route Num			State, Z	ip Code)	_
	Jean H.	Callahan/	Wife	1								aryland 2087	78
	20a. Method of Dis			20b. Place	of Dispo	sition (Name of		bruary 16	20c			own, State	Ť
		☐ Cremation 3 ☐ 5 ☐ Other (Specif)	Removal from State y)	Gate Cemet	erv	natory or other pla eaven	2	009	S:1.	ver S	nrin	g, Maryland	1
	21. Signature of Fu	neral Service Licer	rsee		320	2. Name and Addre	ess of FacilityR	obert A. Pumpl	ney	Funera.	Home	/Rockville, Ir , Maryland 20850	10
	Aulie	eselde	MO	1532	150	o west ii	onegome	ory nvenue	-, I	CCKV	1116	20850	
	23a. Part 1. Enter to shock, or hea	he disease, or com rt failure. List only	plications that caused one cause on each li	the death. Do	o not ent	ter the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,			Approximate Interval Between Onset and Death	
	Immediate Cause disease or condition resulting in death)		a. Cer	ebrovas	scula	ar accide	ent					10 years	
	resulting in death)	•	Due to (or as	a consequence	e of):								
ē	Sequentially list con if any, leading to im	nditions,	b. Due to (or as	a consequence	e of):						-		_
m L	Cause (Disease or that initiated events	injury			,								
Exa	resulting in death) I	Last	Due to (or as	a consequence	e of):								_
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n/Medical Examiner	IF FEMALE:												-
ian/	23b. Was deceden in the past 12	t pregnant months?	23c. If yes, outcome	2 Fetal dea	ith 3	Ectopic pregnanc	су				te of deli	very Day Year	
ysic	1 □ Yes 2 [ 9 □ Unknown		4 ☐ Pregnant a g ☐ Unknown	it time of death	5 L	Other (specify) _							
Completed by Physicia	Part II. Other signif	ficant conditions	contributing to death b	ut not resulting	in the u	n <b>derlying</b> cause gi	en in Part I.	23e. Did	tobacc	o use cont	tribute to	the cause of death?	
d b	Renal f	ailure						1 🗆	Yes	2 <b>X</b> No	3□ Pro	obably 4 🗆 Unknown	
plete								24a. Wa				topsy findings available	-
mo								— auto per 1 □Yes	opsy formed? 2 √7]।	?	death?	ompletion of cause of	
BeC	25. Was case refer examiner?	red to medical					26. Place of	Death (Check only			1 🗀 103	2 0140	_
	1 ☐ Yes 2 🔼		<u> </u>	ent 2 ER/0	<u>-</u>	IL 3 L DOA		ing Home 5 ☐ Res	sidence	6 □Oth	ner (Spec	cify)	
ion:	27. Manner of Deat 1 ☑ Natural	5 Pending	28a. Date of Inju (Month, Da	ıry 28b ı <i>y, Year)</i> 28b	. Time of Injury	Wo		28d. Describe	how in	jury occur	red		
icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not b	e 290 Place of Ini	ury - At home	farm etr	M 1 ☐ reet, factory, office	]Yes 2□No		(Ctroot	and Numb	ar or Du	ral Davida Numbar	_
ertif	4 Homicide	determined	building, et	c. (Specify)	iaini, su	eet, lactory, office		City or To	own, Sta	and ivumi ate)	er or Hu	ral Route Number,	
a C	29a. Certifier	1⊠ Certifying Pl	nysician: To the best	of my knowled	ge, deat	h occurred at the t	ime, date and	place, and due to th	e cause	e(s) and m	anner as	stated.	
Medical Certification: To	(Check only one)	2☐ Medical Exa	niner: On the basis of and manner st	of examination	and/or in	vestigation, in my	opinion, death	occurred at the time	e, date a	and place,	and due	to the cause(s)	
ž	29b. Signature and	title of certifier	A 0	0	7	29c. Licen	se number		29d. I	Date signe	d (Month	, Day, Year)	Ī
		pled	Mulm	el . U	d	D	19294	-/	Fe	brua	w	12,2009	
	30. Name and add	ess of person who	completed cause of o	leath (Item 23a	a) (Type,	Print)	,				1		
			1.D. 911 R		Aver	nue, Gait	hersbu	rg, Maryl	and	2087	9		_
e ar -	31. Date filed (Mon		A P	ar's Signature									
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DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day 15 Year **Physician** Month = 30AM Calvert 16 200 elornew y /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Oct. 21 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. 1 X M 2 □ F Oct. 217-07-9619 92 1916 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7951 Holly Road 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ No 1 ☐ Never Married 2 ☑ Married þ 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Auto Supply 12 Retail Auto Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Η. Calvert Sr. Annie Cook မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Calvert 7951 Holly Road, Pasadena, MD 21122 (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery Glen Burnie, Maryland 4 Donation 5 Dother (Specify) 2009 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the issease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair, re. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final \ once Physician disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine lor Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 X No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 No 2 X No 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within 2 To the F and manner stated. 29b. Signature and title of cer 2 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Year

ALVER

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day ALLEN WAYNE COOL 10:31 PM FEB. 15 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NEW WINDSOR CARROLL 317 MAIN ST., APT. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1**X** M 2□ F 55 212-62-4198 9/30/1953 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h. County CARROLL NEW WINDSOR 1 XIYes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 317 MAIN ST., APT. C 21776 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. Specify:WHITE 3 ☐ Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PLUMBER CONSTRUCTION 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CARROLL G. COOL, SR. MARY LOUISE SHATZER 19a. Informant's Name/Relationship (Type. Print) BROTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARROLL G. COOL, JR. 104 MAPLE ST., MONT ALTO, PA 17237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/17/09 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WINFIELD, MD CARROLL CREMATORY SOUTH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. Thomas D. - letelon IH 254 E. MAIN ST., WESTMINSTER, MD 21157

Approximate Interval Between Onset and Death

Hours

Weeks

2006

Day

1 Month

Year

Physician /Medical

**Physician** 

/Medical

Examiner

10a State

MD

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once.

Director

Funeral

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Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after on the start of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner

Examine Physician/Medical ģ Be Completed Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed At brous after death. Funeral Director: Attenthis certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours aft To the Funeral Di completely filled in

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Respiratory Arrest Due to (or as a consequence of): Respiratory distress -failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Metastatic disease Due to (or as a consequence of) Cancer of Prostate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Emphysema 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) CW3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon

217

32. Régistrar's Signature

WID

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

2+1 State

Registrar

a

31. Date filed (Month, Day, Year

longi

Washington

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	-	_	tificate of	neaith and iv Death	R	eg. No 20 (	)9	04474
	Physicia		1. Decedent's Name (First, Middle, Las  AMELIA C. CUCINA	et)					2. Date of Deat	h	Y <b>24</b> [219	3. Time of Death 7:35 Am
	/Medic Examin	er	4a. Facility Name (If not institution, give Saint Joseph	street and number)	Center		4b. City, Town, or	Location of Death	on	4c. County	of Death	imore
	Funeral Director		213-03-3752		(In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB. 5,	Year) 1915	9. Birthpla Count	ace (State or Foreign ry) MD
	Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD WORCEST	'ER	10c. City, Town		cation				10	d. Inside City Limits 1 ☐ Yes 2 ☐ XNo
:	3a or 288	Funeral Director	10e. Street and Number 165 OLD WHARF RD				10f. Zip Code 2184	2	1	0g. Citizen of W	hat Count	ry?
036	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. The Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evan has must be redified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:			Vas Decedent of H i Yes, specify Cuba □Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America k, White, e	
21215-0036	thin 72 ho te. an "natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5-	+)	(Give I life. L	OO NOT use retired	during most of work i)		16b. Kind of Bu		
and 21	be filed within 72 ntal Hygiene. ed other than "na event, the "tedic	Be	8 17. Father's Name (First, Middle, Last) ANTONIO CARULLO		IN	IDUS	TRY WORK	18. Mother's Name	First, Middle, M	Maiden Surnam	PHONE e)	
aryla	should and Mer s marke umatic	ဥ	19a. Informant's Name/Relationship (	Type. Print)	19b.	Mailin	g Address (Street	and Number or Run			State, Zip	Code)
ore, M	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		JOANNE LIOI-DAU  20a. Method of Disposition  1 K Burial 2 Cremation 3		20b. Place of cemeter	Dispos y, crem	EVERALL sition (Name of natory or other place	ce)		20c. Location -	City or Tov	
	permit. Pages Department of Important: If it any injury or o once.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	1)	MOREL	22	CEMETER  Name and Addre  415 BELA	ss of Facility MI	7/09   LLER-DII ALTIMORI		NERAL	MD HOME, INC
W.	Physician		23a. Par 1. Enter the disease, or o m shock, or heart failure. List of ly Immediate Cause (Final disease or condition resulting in death)	1.	the death. Do re.	not ente	er the mode of dyir					Approximate Interval Between Onset and Death
	/Medical Examiner		•	ATHER		OTI	C CARDI	OVASCUL	AR DIS	EASE		
oʻ	tilicate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. SEPSI	a consequence of a cons							,
68760,	icate be physici the bu	ledical	•	d				7-3-				
. Box	death cer e attendin d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death		Ectopic pregnand Other (specify)	sy		23d. Date Mor	e of delive	ry Day Year
	ss that the de gned by the a	by Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	n the ur	nderlying cause giv	en in Part I.				e cause of death?
Sord	w requires to be a signer should be a	eted	AORTIC STENOSI	S					1 ∐ Ye			ably 4 Unknown
Division of Vital Records,	ding Physician: The law requires that the Arter this certificate has been signed by the funeral director, page 2 should be detache	Completed							autops perfori 1 □ Yes	med? c 2.00 No 1	orior to con leath?	osy findings available npletion of cause of 2 ☐No
<u> </u>	nysicia ils certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ent 2 KER/Ou	ıtpatien	nt 3 DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho	m (Check only on		er (Specify	)
ouo	Attending Ph r death. ector: After th by the funeral	ation: 1	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry 28b. 1	Time of njury	Wor	ry at k?  Yes 2 □ No	28d. Describe ho	ow injury occurre	ed	
Divis	al or Atte s after der al Directo ad in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At home, fa c. (Specify)	rm, stre	eet, factory, office		28f. Location (S. City or Town	treet and Number n, State)	er or Rural	Route Number,
)	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical (	(Check only one) Medical Example one)	nysician: To the best niner: On the basis of and manner sta	examination an	e, death	vestigation, in my	opinion, death occur	red at the time, o	date and place, a	and due to	the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and little of certifier	X J	3	$\geq$	29c. Licens	29931	2	2) 12	Month, I	
			30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type,		BLER DRI	VE, TO	WSON.M	/ ARYL	AND 21204
	Sta Registi		31. Date filed (Month, Day, Year)		ar's Signature	do	Explai					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 08:57 AM それをいせせ 02 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BAYVIEW BALTIMORE HOPKINS MEDICA ENTER If Under 1 Year | If Under 24 Hrs. 7. Age (in yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Sept3,1946 6. Sex Funeral Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Days Hours Min. 62 Director 215-46-8299 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at Md. Baltimore City Director 1 TXYes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or 21224 U.S.A. 618 Savage Street permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s any injury or other traumatic event, the Medical Examine in ust. once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: White 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  $\overset{\text{Elementary/Secondary (0-12)}}{12\,\text{t}\,h}$ College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall G. Goetz Sophia M. Romagnano ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 South Bouldin St. Baltimore, Md. Marsha Hughes (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-18-2009 Baltimore, Maryland Gardens of Faith 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Fuls 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** youx enua O minutes /Medical Due to (ok as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Me fas fatic (ell Small Cancon month Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

PATRICK

MEDICAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940

OFFICER

CASTERN

32. Registrar's Signature

29c. License number

2000

29d. Date signed (Month, Day, Year)

2009

2

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical John Eugene Dayton February 2009 8:50 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs Gilchrist Hospice Baltimore 8. Date of Birth
11/11/1944 9. Birthplace (State or Foreign 5. Social Security Number 7 Age (In vrs. last birthday **Funeral** Months Davs Hours 1 € M 2 □ F Pennsylvania 210-34-8765 64 Director Usual Residence of Decedent 10b. County Baltimore 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the worlds. Parkville 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number s 1 and 2 should be filed within 72 hours after death with tof Health and Mental Hygiene.
item 27 Is marked other than "natural", or items 23a or 2 21234 U.S.A. 8619 Willow Oak Road 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married timore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military Police U.S. Army 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Joseph Dayton Mary Grace McVeigh ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8619 Willow Oak Road, Parkville, MD 21234 Holly Kirby/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 02/17/2009 4 Donation 5 DOther (Specify) Hanover, Maryland 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ESOPHAGEAL CANCER, **Physician** 4EARS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sels consequence of) Examiner The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Completed by Physician/Medical JE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 

Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

O. Box 68760, σ. Division of Vital Records, the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should within 24 hours a To the Funeral L

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

6 ☐ Could not be

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

(Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

FLBRUARY 12, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEMARLES ST, SUITE 209 BALTIMERE, MO 21204 BOBLEMAN MA 6565

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amend #25, 37 & 28a-1 per ME G916 6/28/11 TRT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** ам Davis 3:25 Marcus Gerrod /Medical 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Future Care Balto If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth 4 (Month, Day, Year) 84 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months MD 24 Director 214-06-0346 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1X Yes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 U S A 3170 Ravenwood Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No 1 ☑ Never Married 2 ☐ Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) within 72 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r College (1-4or 5+) N/A Elementary/Secondary (0-12) Disabled 10th grade Disabled 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Pandolia Brown George M. Davis, ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traum 1504 Rutland Avenue Balto, MD 21213 Pandolia Scott-Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1<sup>th</sup> Burial 2 ☐ Cremation 3 ☐ Removal from State MD King Memorial Pk2-14-2009 Randallstown, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H ading Warre 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) mern /Medical Due to (or as a consequence of): Examiner dut Quad Sequentially list conditions, Due to (or as a consequence of). i any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-transi and Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician for use as the buria S Cali Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a detached for 1□Yes 2□No 9 Unknown 9 Unknown The law requires that signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Bouser certificate 2 No 1☐ Yes 2☐No 1 ☐ Yes or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 📉 Yes 26. Place of Death (Check only one) Be 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury 5 Pending investigation Aug, 31, 2006 2:10 pm 1 ☐ Yes 2 No 2 Accident subject was shot 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3300 blk. Elmora Ave. Baltimore, MD determined 4 X Homicide Baltimore, Found: street Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D31464 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) &21 N. ENTAN ST Soute 30 & BALTMORE MIDZIZON SHOAIIS A impi cesti 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State	of Marylar	-	artment of				giene Reg. No.	2000	01.1.79
	Physic		1. Decedent's Name (First, Middle Kenneth J. Da	. ,						2. Date of De Month Februa:	ath		3. Time of Death 2:10 A <sup>M</sup>
A. A.	/Medi Examii		4a. Facility Name (If not institution Stella Maris Ho	, give street and n	umber)		4b. City, Town,	or Location	of Death	100100	4c.	County of Death	
	Funeral Director			6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) 84 Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da March	th ay, Yea <i>r)</i> 15,19	Cou	place (State or Foreign ntry) ew York
	Aaryland f show	b	Usual Residence of Decedent  10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 1 No
	with the N a or 28a-	Director	PA York		N	ew Fre	10f. Zip Code	70/0			10g. Citiz	zen of What Cou	
980	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show matic event, it a Medical Examirer must be notified at	by Funeral	51 Smith Mili  11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 ☒ Divorced	12. Was Dec	cedent Ever in U forces? 2 No live Dates: 45 -		Was Decedent of fYes, specify Cu	ban, Mexica	n, Puerto	ecify Yes or No Rican, etc.)		USA  14. Race - Ameri Black, White, Specify:	
21215-0036	ed within 72 ho /giene. er than "natur i, tre Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	's Education t grade completed	) (1-4or 5+)	16a. Deced (Give life. I	dent's Usual Occ kind of work don DO NOT use retir ter Carr	ed) ed)	st of worki	ng		nd of Business/In	
73	tal do	To Be (	17. Father's Name (First, Middle, L Norman Daviau	*				1 .	er's Name nna	(First, Middle, Janus	Maiden S	Surname)	
, Mar	ges 1 and 2 should t of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationsh			1	ng Address <i>(Stree</i> mith Mil						
imore	Pages 1 ment of H ant; If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		State At	Place of Dispo cemetery, cren Lantic	sition (Name of natory or other pl Cremato	ry	Feb. 200	16,		cation - City or To	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature Trunglal/Selvice Bry	yan W. Cl	Celif	22 L	Name and Add emmon Fu O W. Pad	ess of Facili neral	ty Home	of Du	laney	Valley	, Inc.
	Physician /Medical Examiner		23a. Part1. Enter the dise se, or a shock, or he art failure. List of Immediate Cause (Final disease or condition resulting in death)	a. LUN	c used the deat eath the.  G CANCER  (or as a conseq	h. Do not ent							Approximate Interval Between Onset and Death
68760,	ficate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, 13-55-55 of 10 y that initiated events resulting in death) Last	C	(or as a conseq								
. Box (	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	atcome of pregna birth 2 □ Feta gnant at time of c nown	ideath 3□	Ectopic pregnar Other (specify)	су			23	3d. Date of delive	ery Day Year
rds, P.	Se lo e	þ	Part II. Other significant condition	ns contributing to c	leath but not res	ulting in the un	derlying cause g	ven in Part I.					ne cause of death?
<u>m</u>	The ate h	Completed								24a. Was a autop perfor		24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2  No
of Vit	iding Physician: th. : After this certifica : funeral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 □	Inpatient 2	ER/Outpatien	t 3 □ DOA Ot	hor:		(Check only on ne 5 ☐ Resid		X Other (Specif	y) HOSPICE
Division o	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral	Certification: To	27. Manner of Death  1 Natural  2 Accident  3 Suicide  5 Pending investigation	ation of be	nth, Day, Year)	28b. Time of Injury		ıry at	No 2	8d. Describe h	ow injury	occurred	
Div	pital or Attendons after deatheral Director:		4 ☐ Homicide determine  29a, Certifier 1 ☐ Certifying	build	ling, etc. (Specif	y) 	et, factory, office			City or fow	n, State)	Number or Rura	
	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical	Nurse Prac	Physician: To the xaminer: On the l	pasis of examina	ition and/or inv	estigation, in my	opinion, dea	ith occurre	and due to the e	date and p	and manner as s place, and due to	stated. the cause(s)
	or 5 wit	2	29b. Signature and title of certifier	· Hauf	· CRN	0		se number	9	2		signed (Month,	
	JY'V		30. Name and address of person w				Print) ALLEY RD	_ TTN	ЮИТП	M, MD 2			-
	Sta Registr		31. Date filed (Month, Day, Year)	32. F	Registrar's Signa		1					,	

FEBRUARY 14, 2009

KENNETH DAVIAU

			Pleas	se Type or Prir				•		gible.	
			For State Registrar	State of Ma	•	epartment of h Certificate of			giene <sub>Reg. No</sub> 2 (	200	04479
	Physicia		1. Decedent's Name (First, Middle	,				2. Date of De	ath	Year	3. Time of Death
	/Medic	al	Mi 4a. Facility Name (If not institution		owell	4h City Town o	r Location of Death		1, 200	nty of Death	9:30 PM
	Examin	er		a Maris Hosp	ice		Timonium		40. 000	Balti	more
	Funeral		5. Social Security Number 191-22-4443		e (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		19			Feb. 2	0, 192		yland
arvian	show	'n	10a. State 10b. County		10c. City, Town						10d. Inside City Limits 1 ☐ Yes 2X No
the M	r 28a-f	Director	Md. Ba	<u>ltimore</u>		Parkvi 10f. Zip Code	lle		10g. Citizen	of What Cou	ntry?
ath with	23a o ust be		2407 Hillfo	rd Drive			21234			USA	
:1215-0036 within 72 hours after death with the Marvland	items	Funeral	11. Marital Status 1 ☐ Never Married ②★Marr	12. Was Decedent I Armed Forces? ied 1 ∐Yes 2 1 ☐ 1		13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	)-   14. F	Race - Ameri Black, White,	can Indian, etc.
5-0036	ral", or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2√XNo	Specify:		Spe	ecify:	White
15-0	"natu edical	Completed	15. Decedent (Specify only highes	st grade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wor.	king	16b. Kind o	f Business/In	dustry
2121 d within	giene.	Comp	Elementary/Secondary (0-12)	College (1-4or 5	)+)	Homer	maker			n Home	<u>.</u>
and 2	de	Be	17. Father's Name (First, Middle,	<sub>Last)</sub> omas Freela	ind		18. Mother's Nan	ne (First, Middle lizabet		<sub>name)</sub> ffith	
Maryland 21		2	19a. Informant's Name/Relations			Mailing Address (Street					p Code)
	m 27 ls			/Husband		407 Hillford	d Drive	Parkvil			
more			20a. Method of Disposition  1 XBurial 2 Cremation		cemeter	Disposition (Name of ry, crematory or other pla	1	Date 4.400		on - City or T	
Baltimore,			4 □ Donation 5 □ Other (S		1 Cedar	Hill Cemeter 22. Name and Addre		4/09 uck Tow			aryland Home, Inc.
<u> </u>	8 5 5 8		Mucha	of The	8/	1050 York		owson, l	- 10	nd_212	
	!-!		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final			not enter the mode of dy	ng, such as cardiad	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	nysician Medical		disease or condition resulting in death)	a. OVARIAN  Due to (or as	a consequence	of):					
E	xaminer	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	off:					
, executed	an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C	a oonooquenoo						
	cian an ourial-tr	_	resulting in death) Last		a consequence	of):					
I Records, P.O. Box 6876( The law requires that the death certificate be	attending physicia for use as the bur	Physician/Medical		d							
SOX th cert	tending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	of pregnancy 2  Fetal death	3 ☐ Ectopic pregnan	су		23d.	Date of deliv	very Day Year
P.O. E	ned by the at detached fo	ysici	1 ☐ Yes 2 <b>X</b> No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (specify) _				WOULD	Day Tour
<b>6</b> , 10	signed by	by Ph	Part II. Other significant condition	ons contributing to death b	out not resulting in	the underlying cause gi	ven in Part I.	23e. Did	tobacco use o	contribute to	the cause of death?
ord	should b										bably 4 Unknown
Rec he law	e has t	Completed							psy ormed?	prior to co death?	opsy findings available ompletion of cause of
ital	nis certificate h director, page	Be Co	25. Was case referred to medical examiner?				26. Place of Dea	1 □Yes ath (Check only		1 □Yes	2 LINO
of V	this ceral dire	၉	1 Yes 2 No 27. Manner of Death	Hospital: 1  Inpatie		ttpatient 3 □ DOA Ott		lome 5 ☐ Res			ify) HOSPICE
ion and	ath. r: After e funera	ation	1 Natural 5 Pendin 2 Accident investig	g (Month, Da		njury Wo	rk? ]Yes 2 □No	200. Describe	now injury ou	ourrou	
Division of Vital Records,	within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	sined   28e. Place of Irij	ury - At home, fa c. (Specify)	rm, street, factory, office		28f. Location ( City or To	(Street and Ni wn, State)	umber or Rui	ral Route Number,
	hours a			ng Physician: To the best							
the Ho	within 24 I	fedical	one X Nurse Pra					urred at the time			
Ē	with con	Σ	29b. Signature and title of certifie	7-PMAIP		29c. Licen	se number		29d. Date si	gned (Month) $2/(9)$	, ∪ay, rear)
,			30. Name and address of person	who completed cause of o	death (Item 23a)	(Type, Print)	11110		411	10/	
/	) \		JACKIE JONES, 31. Date filed (Month, Day, Year)	CRNP 2300 I	OULANEY	VALLEY RD.	TIMONIUM	, MD 21	093		
	Sta Registr		FEB 1720		p. 19	ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fh g889 3-10-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Ye ar **Physician** ROBERT DILAURO FEBRUARY 07:47 AM 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/11/1928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 201-20-7381 80 PA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, It a Medical Examinat must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Farms Drive 21144 8148 Quarterfield Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1☆ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify ≥ 3 ₩ Widowed 4 Divorced  $\mathsf{Robert}$  D1/GL Baltimore, Maryland 21215-003 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Co. Elementary/Secondary (0-12) College (1-4or 5+) Police Dept. Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincenzo DiLauro Maryann Ranalli ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Diane Tacka / daughter 2595 Stanford Dr.; York, PA 17402 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Atlantic Crematory 2/16/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Fuheral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTEKY. disease or condition resulting in death) CORONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DISEASE been si KIDMEY Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? 1 □ Yes 2 No death? 1 ☐ Yes 2 🗷 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00054739 February 16th 2009 Curry Posina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2+1 GLEN BURNIE MARYLAND 21061 7845 DAKWOOD SUITE ROAD 204

State

Registrar

31. Date filed (Month, Day, Year)

172009

32. Registrar's Signature

Examiner Hospital or Attending Physician; The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-tran Division of Vital Records, P.O. Box 68760,

28a-f show

Baltimore, Maryland 21215-0036

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

1 ☐ Yes 2 ☐ No

. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

(Check only one)

29c. License number D805910

DRIVE

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUSINESS 31. Date filed (Month, Day, Year)

32. Registrar's Signature

REISTERSTOWN

NO 21136

State Registrar

Medical

24 hours after deat Funeral Director:

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Charlotte Deibel February 6, 2009 11:15P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/18/1931 Birthplace (State or Foreign Country) **Funeral** 218-28-4485 Months Days Hours Min. Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Examinant must be not filled at 10d. Inside City Limits MD Baltimore Halethorpe Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 Park Ave 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? I∐Yes 2**X** No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify: 2 White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) Oliver Peach Florence Ensor ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur Laura Ann Wiegmann / daughter 8563 Chris Court Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial: 02/13/2009 Elkridge, Maryland 4 □ Domation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral S vvice Licens 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Carcinoma months /Medical Due to (or as a consequence of): Metastases **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical use as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fi P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page 2 certificate Vital 1 □Yes 2 No 2 No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of HOSPILC After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) QUAN DONG NGUYEN 53275 February 7,2009

DHMH 17 Rev 1/2001

State

Registrar

0/90100

Died 11:15pm

DEIBEL

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CHAR

MARY

N.

Welle

Street

600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

NGUYEN

DONG

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04483 Reg. No 2009 Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 02711/2009 **Physician** Doris V. Etheridge 1605 hr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney If Under 1 Year Montgomery General Hospital Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 🔭 Months Days Hours Min 302-05-5306 11/24/1917 Director Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show 1 ☐ Yes 2 No Director MD Montgomery Brookville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö items 23a 3520 Brookmark Terrace 20833 Funeral United States Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Executive Housekeeper 12 Cleaning Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. Frank Irvin Loly M. Irvin (Phillips) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Mrs. Lois Leigh (Niece) 3520 Brookmark Terrace, Brookville, Maryland 20833 of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Rest Memorial 02/16/2009 Reynoldsburg, Ohio △ Donation 5 Other (Specify) 22. Name and Address of Facility 21, Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preymoni **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) P.0. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ arler 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? Kidney 2 PNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 LANG Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ata motamedi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

MS

29c. License number

18111 Prince Philip Dr #101, Dlney MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04484 Certificate of Death Reg. No 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2/14/2009 Shirley Jeanne Erbe 2:30 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Lorien Nursing & Rehab Center Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1/07/1925 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min. 1 M 2 M F 398-12-6317 Director 84 Usual Residence of Decedent with the Maryland 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 □Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 115 Furnlea Drive 21060 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Exemiter contents. by Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Mayes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 | No 1 ☐Yes 2 TNo Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmotologist Cosmetics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Veron H. Hiebel ပ Laura G. Wichman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Pam Conwell / daughter 8025 Greentree Ct.; Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 12/20/2009 Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Lipensee Services, PA; 1 2nd Ave SW; Glen Burnie, MD21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or all a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Due to (or as a consequence of) be executed the burial-transi Lbrovasc and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) Day Year detached 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 🗆 Yes 3 Probably 4 Unknown DULMONAVI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate ettussion de 2 □No 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: this Medical Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Registrar

(Check only one)

31 Date filed (Month, Day, Year)

7

who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

ledar.

29d. Date signed (Month, Day, Year)

#103

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	Ji Mai yiaii		rtificate of	Death		Reg. No.	09	04485
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Wanda	a Faye	Fleet			Month 2	8 2	20 <sup>Ye ar</sup>	2,00PM
The same	Examin		4a. Facility Name (If not institution, give street and n	,		4b. City, Town, o	r Location of Death		4c. Count	ty of Death	
			Ravenwood Nursing				e Md. 2		NA		
	Funeral		5. Social Security Number 6. Sex 1 M 2 1 M 2 1 M 2 1 M 2 M 2 M 4 M 2 M 2	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	v. Year)	9. Birthp	lace (State or Foreign htry)
	Director	ļ	Usual Residence of Decedent	47	110.			9 3	1961		N.C.
	yland Now		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Mar Mar	ig	MD N/A	Ba	ltimo	re					1X Yes 2 □ No
	or 28	ire	10e. Street and Number		<u> </u>	10f. Zip Code			10g. Citizen of	What Coun	try?
	23a	<b>Funeral Director</b>	501 Dolphin Street			2121	7		Ţ	J S A	
	tems	ne	Armed F		.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner I, ust by notified at once.	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or	2 □ No hive		1 □Yes 2□No	Specify:		Speci	fy:	Black
21215-0036	tural	ed	15. Decedent's Education	Jales.	16a. Dece	dent's Usual Occup	oation		16b. Kind of F	Business/Inc	dustry unk
212	7. nin 7. 3. ni * 3. ni *	Completed	(Specify only highest grade completed	) (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most Pusrkii	ng			unk
21	d with giene er the	S S		/A							
pu	al Hy a oth	Be (	17. Father's Name (First, Middle, Last)	,		ĺ	18. Mother's Name	(First, Middle,	Maiden Surna	me)	
yla	Ment arked	မ	Floyd P. Coples				Leatha				
Лаг	2 sho and Ism raum		19a. Informant's Name/Relationship (Type. Print)	,			and Number or Rura				
e)	l and Health Sm 27 Sm 27 Sher t		Leonard Coples-Brot				g Street		imore		
Baltimore, Maryland	nt of h		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from	State Cr	cemetery, crer Cenatery, crer	sition (Name of natory or other place	<sup>(e)</sup>	-2009	20c. Location Balto	•	wn, State
Ħ	it. Partitude intrant		4 Donation 5 Other (Specify)	GIV		. Name and Addre	i .				
Ba	Depa Impo any I		21. Signature of Funeral Service Licenseu  Blown D Jumps				North A	arch E venue	ast F/ Balt	'H :0, M	D 21202
			23a. Part 1. Enter the disease or complications that shock, or heart failure. Jist only one cause on	caused the death	h. Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
E.	Physician		Immediate Cause (Final disease or condition	each line.		S 1329	n		55 Y		Onset and Death
	/Medical		resulting in death)	(or as a consequ	uence of):	1	Lise	maszy	nx L	eng	tanding
	Examiner	L	Sequentially list conditions. b			/		v			
	₽;/ # <u>#</u>	Examiner	Sequentially list conditions, b. Dun to cause. Enter Underlying Cause (Disease or injury that initiated events	(Ur as a cunsiiqi	uence offi:						
	and al-tran	xan		(or as a consequ	uence of):				-		
68760,	rtificate be executed in physician and as the burial-transit			,							
687	ificate g phy as the	Medical	d				-				
				itcome of pregna		-			23d. Da	ate of delive	rv
	0 0 0	Physician/	in the past 12 months?	birth 2□Fetal gnant at time of d		] Ectopic pregnanc ] Other (s <i>pecify</i> )	у				Day Year
P.O.	at the by th tache	hys	9 ☐ Unknown 9 ☐ Unk	nown				-			
s,	v requires that the d been signed by the should be detached	by F	Part II. Other significant conditions contributing to c	leath but not resu	ulting in the ur	nderlying cause give	en in Part I.				e cause of death?
ord	requir een s rould	ted	Respiratory du	ficul	ty,	rache	205 Tony	£1 □ Y	es 2 □ No	3 Prob	ably 4 Unknown
Records,	has b	Completed	Malnutrition		0		0	24a. Was a	sy		osy findings available appletion of cause of
a E	: The cate ; pag	So						perfor 1 □ Yes		death? 1 🔲 Yes	2 1 <b>7</b> No
<u> </u>	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?  Hospital: Hospital:			t s Doo Othe	26. Place of Death	(Check only or	ne)		
Division of Vital	al d alia	5	1 ☐ Yes 2 🙀 No 1 ☐ 27. Manner of Death 28a. Date	Inpatient 2	ER/Outpatien 28b. Time of	IL 3 LI DOA	4 Nursing Hor	ne 5 Resid			")
o	nding F th. : After : funera	ţi	1 ☐ Natural 5 ☐ Pending (Moil 2 ☐ Accident investigation	nth, Day, Year)	Injury	Worl	(? Yes 2 □No	ou. Describe II	Ow injury occur	red	
S	al or Attendii s after death. I Director: A id in by the fu	ifica	2 Deviate 6 Could not be	ا e of Injury - At ho ling, etc. <i>(Specif</i> )	me, farm, stre			28f. Location (S	treet and Num	ber or Rural	Route Number,
ā	tal or s afte al Dir	Certification:	4   Hornicide Dulic	ing, etc. (Specif)	y)			City or Tow	n, State)		
	Hospil 4 hour uner ely fill		29a. Certifier 1 Certifying Physician: To the	e best of my know	wledge, death	occurred at the tir	me, date and place, a	and due to the	cause(s) and m	nanner as st	ated.
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical	one) and mar 29b. Signature and title of certifier	nner stated.							
	5 ¥ 6 0		200. Signature and title of certifier			29c. Licenson		2	29d. Date signe	ed (Month, E	yay, Year)
	1		20 Name and address of a	an of death div	000\ /T		2		4/13	109	
_	/		30. Name and address of person who completed cau	,		*	A			. ^	
	Sta	te	SATPAL S. DANG M. D. 101 31. Date filed (Month Day, Year) 32. 1	Registrar's Signat	ture C	TVE BI	HLTIMORI	= IMD	2 2 2		
	Registr	ar	FFR 1 7 2009	Experient	B. A.	arkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [9] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY Day. EYERZI9 Evelyn Elizabeth Flottemesch 12:35PM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Center 8. Date of Birth (Month, Day Ye Aug. 14, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1924 1□ M 2 F Months Days Hours Min. Maryland 214-26-6512 84 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛛 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 905 Magnolia Road 21085 Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2X No 9 Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H Item 27 is marked oth r other traumatic even Be Paul Peter Mehr Evelyn Deloris Geary ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Joseph Flottemesch / Son <u>3409 Philadelphia Road, Abingdon, Maryland 21009</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 D Burial 2 □ Cremation 3 □ Removal from State St. Stephens Cem. 2/16/2009 4 Donation 5 Dother (Specify) Bradshaw, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC LUNG CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in its diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and ng physician and as the burial-transit Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 1 Tes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? 1 ☐ Yes 2 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of eath
1 Natural
2 Accident Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DØØ17695

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Spinature FEB 1 7 2009 FEB 1 7 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE

TOWSON, MARYLAND 21204

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy 2 MNo 1 □Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 ☑ Natural

STEVEN

31. Date filed (Month, Day, Year)

2 Accident

4 Homicide

3 Suicide

29a. Certifier

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) 28b. Time of Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number 53850 29d. Date signed (Month, Day, Year) FEBRUARY 12, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Inpatient

4940 EASTERN AVENUE BALTIMORE MD SCHULL HILT 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

るロンジアゼム LOANN

> Box 68760. P.O. Division of Vital Records,

detached ģ director, page 2:

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Completed

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Certification: To

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filled in by the funeral

completely

• Hospital or Attending Physician: The law requires the 24 hours after death.
• Funeral Director: After this certificate has been signs

To the I within 2

**Physician** /Medical Examiner

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attending physician

certificate be executed

P.O. Box 68760.

Division or Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

filled in by the

**Physician** 

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notifled at

Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event, It

other

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

and manner stated.

26. Place of Death (Check only onle

Other: 4 Nursing Home Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature

2 No

5 Pending investigation

6 ☐ Could not be

determined

1 TYes

Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29c. License number OS

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES S. ANGELL, M.D. 10755 FALLS ROAD, STE 200, LUTHERVILLE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

XI

#### For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2009 Willard D. Fountain rebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Jarrettsville 1902 Furnace Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 0ct. 8, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 73 219-30-6635 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Director Jarrettsville MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21084 USA 1902 Furnace Road items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No 'natural", or If Yes, Give Year or Dates: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Finance Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry A. Fountain, Sr. Willard D. Minor ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Betsy Carol Fountain wife 1902 Furnace Road; Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Comation 3 Removal from State Lakeview Mem'l Park 2/14/09 4 Donation 5 Dother (Specify) 21. Signature of Funeral 22. Name and Address of Facility Ruck Towson Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stage Rend Due to (or as a consequence of): **Physician** Kenal disease or condition resulting in death) /Medical Examiner Diabetic Nephropathy Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by CORONARY ARTEMY DISEASE 24a. Was an CALDIOMYOPATITY autopsy performed MYOCARDIAL INFANCTION NON QWAVE 1 ☐Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No veral Director: A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

20c. Location - City or Town, State Sykesville, MD 1050 York Road Towson, MD 21204 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) SMHLANGRUE SVITE 203

3. Time of Death

10d. Inside City Limits

white

1 ☐ Yes 2 ☑ No

0500 M

State Registrar

within 24 hours a To the Funeral C

Medical

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2835 32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

won

arakaat Sarva Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 10, 2009 Medical Examiner 2129 hrs Barakaat Faruq 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** University Hospital 5. Social Security Number If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** 7. Age (In yrs, last birthday) Months Days Hours Director Country) 1 X M 2 F 2<u>17-23-6556</u> 11-25-1988 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show N/A 1 X Yes 2 No MD Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 4952 Clifton Ave USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? White, etc. 2 X No Yes 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify African American ੬ 16b. Kind of Business/Industry N/A 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Never Worked 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Karim Faruq Lisa Bess 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4952 Clifton Ave Baltimore, MD 21207 Lisa Bess 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 02-16-2009 King Memorial Park Randallstown, MD Donation 5 Other Specify 22. Name and Address of Facility rice Licensee Wylie Funeral Home P.A. 638 N. Gilmore Street Baltimore, MD 21217 23a. Part I. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease **kaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. transi sician/Medical UNPENDED attending physician or use as the burial -AMENDED Division of Vital Records, P.O. Box 68760, 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Month Year Day 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 Yes After 1 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Feb 10, 2009 (Month, Day Year) Subject shot Natural 5 Pending Yes 2 V No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State) 2122 Presbury Street, Baltimore, MD (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death.

To the Funeral Director: A

31. Date filed (Month, Day, Year) State Registrar

**DHMH 17 Rev 1/2001** 

CME 2006

29b. Signature and title of certifier

Russell Alexander MD.

17 2000

and manner stated

Assistant Medical Examiner

82. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 11, 2009

OCME

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** WILLIAM VICENT FABRICK 4. 2009 5:20 FEB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 218-64-5476 58 Director 9/16/1950 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1041 HUGHES SHOP RD. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 2 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HEAVY EQUIPMENT OPERATOR 12 should be filed w h and Mental Hygien 7 is marked other th CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be WILLIAM JOSEPH FABRICK, SR. DOLLY MARY DEITZ 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun HUGHES SHOP RD., WESTMINSTER, MD 21158 EDITH K. FABRICK WIFE 1041 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State /18/09 4 □ Donation 5 Other (Specify) EVERGREEN MEM.GARDENS FINKSBURG, MD nature)of 21. Si neral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD Approximate Interval Between Onset and Death 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 48hrs /Medical Due to (or as a consequence of): uehro Examiner Myocksial Infaction HWIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Anteru COLONAU and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 X Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an has autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending Plant 24 hours after death. 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Francis K. Gerevis in mo D31660 02/16/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMS K. Muganc WESMINSTER moulas CALXIN AN THE 31. Date filed (Month, Day, Year) 32. Righstrar's Signature State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	of Marylar		artment of H		and Mental H	ygiene Reg. No	2000	04	492
	Dharis		1. Decedent's Name (First, Mide	dle, Last)				_	2. Date of I		v Year	3. Time o	f Death
	Physici /Medio		Elaine Lois	Fisher					Febru	ary Ï	2, 2009	4:30	РМ
	Examir		4a. Facility Name (If not instituti	on, give street and no	umber)		4b. City, Town, or	Location o	f Death	4c	. County of Death		
4			Collingswood Nursi				Rockvil				ontgomer	<i>'</i>	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min. (Month,	Birth Da <i>y, Y</i> ea <i>r)</i>	l Cou	place (State ntry)	
	Director		049-16-4776 Usual Residence of Decedent		83	Yrs.			March	4, 1	925 Conn	ecticu	ıt
	and and		10a. State 10b. Count	у	10c. Cit	ty, Town or Lo	cation					I 0d. Inside C	City Limits
	Mary f sho	ō	Maryland Montg	omoru	Ger	rmantov	<i>I</i> n					1 ∐Yes	2 <b>∑</b> No
	death with the Maryland ims 23a or 28a-f show ir invist be ricifited ■t	Funeral Director	10e. Street and Number	omer y			10f. Zip Code			10g. Cit	tizen of What Cou	ntry?	
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	ms 2	Jere	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.		ispanic Orig	gin? (Specify Yes or f , Puerto Rican, etc.)		14. Race - Ameri	can Indian,	
ည	riter of		1 ☐ Never Married 2 ☐ Ma	Armed Formed Formed 1 □Yes	2 🗙 No				, Puerto Rican, etc.)		Black, White,		
03	hours after tural", or ite	ğ	3 ☑ Widowed 4 ☐ Divorce	d If Yes, G Year or E	oates:		1∐Yes 21X∏No	Specify:			Specify: Wh:	ite	
5-0036	n 72 hours after death with the Marylan "natural", or items 23a or 28a-f show caffeel Examiner mast be northed at	Completed	15. Decede	ent's Education est grade completed)		16a. Dece	dent's Usual Occup	ation during most	of working	16b. K	ind of Business/In	dustry	
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12	led w lygiel her ti			- 1 1)	2	Homen	laker	40. 14-15-	de bloom / Class Stinda		wn Home		
ınd	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It a M.	Be	17. Father's Name (First, Middle	, Last)					r's Name (First, Midd		Surname)		
<u> </u>	ould Mer narke	၉	Bert Pooley			T			sie Kenhar	-			
Maryland	12 sh h and 7 is n traun		19a. Informant's Name/Relation Rhonda Ricci/D			1 .			r or Rural Route Nun				
	1 and Healt Sm 27			augnter	205 5				e, Rockvil	<del>,                                    </del>	Clary Land ocation - City or To		
Baltimore,	it of h		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Removal from	State		sition (Name of natory or other plac	: 1	ebruary 17,				
ŧΪ	t. Pa rtmer rtant:		4 ☐ Donation 5 ☐ Other (		Mont		rematorium		2009		hesda, M	arylan	ıď
Bal	permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, II an once.		21. Signature of Funeral Service	Blit	M0154	48 Ro	bert A. Pum West Mont	ohrey Fi	uneral Home/ Avenue, Rock	Rockvi ville,	lle, Inc. Maryland 2	20850	
			23a. Part 1. Enter the disease shock, or heart failure. Lis	or complications that	caused the deat each line.	h. Do not ent	er the mode of dyin	g, such as	cardiac or respiratory	arrest,		Approximat Interval Be	te tween
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-1	/Medical		resulting in death)	Due to	(or as a conseq	uence of):		545					
	Examiner		Sequentially list nonditions				MCTIVE	Pu	LMONARY	DI	SEASE		
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	and -tram	Examiner	that initiated events resulting in death) Last	U	OIABET		MELLITA	(7.					
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87	physi the b	dic		d. (1) F	NOR	7 // /	JERY	DISE	ENG C				
9 ×	eath certific attending p for use as	Physician/Medical	IF FEMALE:	23c If yes ou	itcome of pregna	ancv					0010-1-11		
Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	Ideath 3	Ectopic pregnancy Other (specify)	У			23d. Date of delive Month	•	Year
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σ.	res that the de signed by the a be detached to		Part II. Other significant condit	ions contributing to c	leath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	i tobacco i	use contribute to t	ne cause of o	death?
Vital Records,	uires sign d be	d by							1 🗆	Yes 2	XNo 3 Prot	ably 4	Unknown
200	w requir been s should	Completed							24a. Wa	e an	24b. Were auto	ney findings	available
Re	ne law has ge 2 a	ᇤ							— aut	opsy formed?	prior to co	mpletion of c	ause of
a	n: Th ficate f, pa		OF Management to modify	at I		<del></del>			1 □ Yes	2 X No	1 ☐ Yes	2 No	
Ζ	ding Physician: The In. After this certificate hit funeral director, page	a	25. Was case referred to medic examiner?  1 ☐ Yes 2 No	Hospital:			Othe		of Death (Check only				
of	Physral di	은	27. Manner of D ath		Inpatient 2  of Injury	28b. Time of	it 3 🗆 DOA	4 EL Nur	rsing Home 5 Re			(y)	
on	ding h. Afte fune	ţ	1 Natural 5 ☐ Pend	ing (Mor tigation	of Injury oth, Day, Year)	Injury	Work	(?¯` Yes 2 □ N		o non injui	y occurred		
S	i or Attendi after death. Director: A	lica	3 ☐ Suicide 6 ☐ Could	l mot be	e of Injury - At ho	ome, farm, str	eet, factory, office			(Street ar	nd Number or Rura	l Route Num	nber.
Division	after after Dire	Certification:	4 ☐ Homicide deter	build	ling, etc. '(Specit	(y)	,		City or T	own, State	)		
	splta ours neral		29a. Certifier 1 CertIfy	ing Physician: To the	e best of my kno	włedge, deatl	occurred at the tir	ne, date and	d place, and due to the	ne cause(s	) and manner as s	tated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		I Examiner: On the I									<b>;</b> )
	To th withir To th comp	Me	29b. Signature and title of	e(r)			29c. License	e number		29d. Da	te signed (Month,	Day, Year)	
	И		the				73	0/32		02	/12/	2009	7
	"		30. Name and address of perso	n who completed cau	se of death (Iten	n 23a) (Type,	Print)				/ / /		
	9		M-ROTE Ghi	OSH M-D	. 148	12 PH	YSICIALS	LAN	E #161 R	KKU1	LE MD	52085	7
	Sta	te	31. Date filed (Month, Day, Year	) 32. [	Registrar's Signa	iture			// /		1		
	Registr	ar	FFR 17	2009 2	ma A	bar	Ked						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year Clinton Clair Glenn, Jr 8:45 PM 2009 February 04 /Medical Clinton Claire 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville 15 Oakridge Court If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/01/1933 9. Birthplace (State or Foreign Country)
Pennsylvania Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Months Director 75 163-26-1893 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show any highry or other traumatic event, the Medical Eventuer must be notified at 90.ce. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ∐Yes 2**x** No Funeral Director MD Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21093 15 Oakridge Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Presbyterian Church Minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes Patton Clinton Clair Glenn, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8705 Grant Street, Bethesda, MD, 20817 Cynthia Souza/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  $02/09/2009 \mid Hanover, Maryland$ Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** esophagea disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. Atter this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 1 ☐ Yes 2 🖼 25. Was case referred to medical examiner? 26. Place of Death (Check only ong Other: 4 Nursing Home 5 Besidence Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury To the root.

Within 24 hours after deau.

To the Funeral Director: Aft 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10~50 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** epruari Henrietta Greene /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner altimore Jakylana N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Nov 21 ay 1918 9. Birthplace (State or Foreign Age **Funeral** Days Hours 1 □ M 2 K F 90 North Carolina 243-34-1348 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it. Medical Experiment by notified at once. MD Baltimore N/A 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 2327 N. Charles Street USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Domestic Private Homes 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williamson Susan King Irvin James ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Walnut Street, Reidsville, NC Evelyn Reed - niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 02/16/2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Se <sup>22. N</sup>Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21 Steven H. Williams 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence Examiner SSINL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) ed by the 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has b autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated.

N

32. Registrar's Signato

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 6001 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner BALTIMORE REHABILITATION EXTENDED 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Davs MM 2 F 84 8-11-1924 216-16-1229 Director MD Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercines is used to notified at 1 TYes 2 □ No **Funeral Director** Baltimore N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U S 21215 2503 Violet Avenue death 12. Was Decedent Ever in U.S. Armed Forces? → Effes 2 □ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ♠ No Specify Specify: Black <u>გ</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arneida Bowie Maxie Gooden ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 1206 19a. Informant's Name/Relationship (Type. Print) Franklin Street Balto, MD 21201 Lillian Gooden-Wife 124 W. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If iter any Injury or ott once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2-13-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee North Avenue Balto, 21202 MD 1101 Ε. ) and 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner EUROENIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician a Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral L Hospitai 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLVD 3900

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

Registrar's Signature

P.O. Box 68760, Records, Division or Vital | To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

Registrar

State

29b. Signature

30. Name and address of

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar's Signature

cause of death (Item 23a) (Type, Print)

3029

29c. License number

29d. Date signed (Month, Day, Year)

ave Bath

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 14, 2009 Marguerite D. Girgash 1:34 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 30 Bideford Court 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 4/26/1923 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Pennsylvania 183-12-4574 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Parkville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21234 USA 30 Bideford Court or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after of teath and Mental Hygiene. m 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 if Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Executive Assistant** Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria D'Agostino Antonio Del Duco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Bideford Court Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau Thomas J. Girgash/Husband Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Serv. Corp. 2/18/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VW **Physician** rear disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Completed by Physician/Medical Examiner Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) O. Box 68760, Physician: The law requires that the death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy P Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 2 XNo Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) nours after death.

neral Director: After this y filled in by the funeral di After this 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending 5 Pending investigation ccident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date fifed (Month, Day, "Year,

Charle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

679

32. Registrar's Signature

6,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 9, 2009 **Physician** William С. Gob1e 2:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Frederick Villa Nursing Center Catonsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F Yrs. Director 9/9/12 Virginia 96 218-01-6032 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanther must be notified at 1 ☐ Yes 2 No Director MD Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 21227 USA 4801 Ruby Ave. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or ite 1 Mes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Mechanic Machinery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lilly Foster H. M. Goble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 704 Charing Cross Rd. Baltimore, Maryland 21229 Item 27 i Heather Goble / Granddaughter permit. Pages 1 a Department of Her Important: If Item any Injury or othe once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/12/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signeture of Funeral Service Life 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Pert 1. Enter the disease, or conshock, or Heart failure. List fally Do not enter the mode of dying, such as cardiac or respiratory arrest, iplications that caused the death. one cause on each line Immediete Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Unicease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burlal-transit death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending pl for use as tl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 1 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Hospital: Other: Nursing Home 1 ☐ Yes 2**/2** No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature at

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical

Division of Vital Records, P.O. Box 68760,

		For		State of I	Maryland /	-		f Health and	Mental Hygie	ene	0.0	01100
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Examir	er	4a. Facility Name (I	-					n, or Location of Deat	h		ty of Death	
		5. Social Security N	sElderca		1tage Age (In yrs. last	hirthday)	Dund If Under 1 Ye		8. Date of Birth	Balt	imore	
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and r		19a. Informant's N	ame/Relationship (	Type. Print)	1	9b. Mailin	g Address (Str	eet and Number or R	ural Route Number, (	City or Tow	n, State, Zip	Code)
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Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maclical Examination and the radial at once.		20a. Method of Dis	position □Cremation 3 □	Bemoval from Sta	20b. Place ceme	e of Dispo etery, cren	sition (Name o natory or other	f place)	Date 20	c. Location	ı - City or To	wn, State
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igned be de	by	Part II. Other signi			th but not resultin	g in the ur	nderlying cause	given in Part I.				e cause of death?
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as be	Completed	MAL	HUTR	171011					24a. Was an autopsy	24b	. Were autop	osy findings available impletion of cause of
page	Son								performe	ed? ∃No	death? 1 ∐Yes	
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this o	ဥ	1  Yes 2			patient 2 ER	<u>-</u>	1 3 DOA		Home 5 Residen			)
h. After funera	ion:	27. Manner of Deat	5 Pending		Day, Year) 28	b. Time of Injury	'	njury at Work? 4.□V 2.□No	28d. Describe how	injury occu	urred	
tor:	icat	2 Accident 3 Suicide	investigation 6 ☐ Could not be	e	Injuny At hom-	form of		1 □Yes 2 □No	28f Location (Ct.)	ot and M.	abor as Com	I Douto Numb
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ra led	ပိ	ļ		- 1								

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

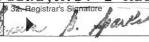
D027188

February 16, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Market Place Dundalk, Maryland 21222 Savinder Julka,M.D.

31. Date filed (Month, Day, Year) State Registrar



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04500 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 12:20 a M February Heffner Alfred George 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Westminster Golden Living Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 4 1949 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) 216-52-4184 1 M 2 □ F 60 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes No Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 1234 Washington Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 N Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Baltimore Sun Deliveryman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

Gertrude

Manchester, MD21102

Evelyn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

136 Chargeur Road, Reisterstown, MD 21136

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, It is Institute once.

1 - For State Registrar

10a. State

Lawrence

MD

**Physician** 

/Medical

**Examiner** 

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

Director

Funeral

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Be Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Certification: To

Division of Vital Records, P.O. Box 68760,

4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		<sup>22</sup> Name and Cremat	, Inc. 02/2	of Maryla		
23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition		not enter the mode		c or respiratory arrest,	re, MD	Approximate Interval Between Onset and Death
resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence  c. Due to (or as a consequence  d.	of):	raisents	Desine		25 Jr
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 4  Pregnant at time of death 9  Unknown	n 3 ☐ Ectopic pre 5 ☐ Other (spec			23d. Date of d Month	elivery Day Year
Part II. Other significant conditions	contributing to death but not resulting in	n the underlying cau	se given in Part I.	23e. Did tobacc		to the cause of death?  Probably 4 🗌 Unknown
				24a. Was an autopsy performed	prior to	eutopsy findings available o completion of cause of ? es 2 \( \) No
25. Was case referred to medical examiner?			T	ath (Check only one)		
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 ☐ DOA	Other: 4 Nursing I	Home 5 ☐ Residence	6 ☐ Other (Sp	pecify)
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day, Year)	Time of 28 Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
3 Suicide 6 Could not be determined		arm, street, factory, o	office	28f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
29a. Certifier 1 Certifying Pi (Check only one) 2 Medical Exa	nysiclen: To the best of my knowledgeminer: On the basis of examination at and manner stated.	e, death occurred a nd/or investigation, i	t the time, date and place n my opinion, death occ	ce, and due to the causeurred at the time, date	e(s) and manner and place, and di	as stated. ue to the cause(s)
29b. Signature and title of certifier		29c.	License number	29d.	Date signed (Mor	nth, Day, Year)

Heffner

address of person who completed cause of death (Item 23a) (Type, Print)

Walter

19a. Informant's Name/Relationship (Type. Print) E. Romaine Mullaney - sister

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State Registrar